2022 FAQ
ACCLARENT CODING AND REIMBURSEMENT
Physician and Facility

Acclarent devices are sold by or on the order of a physician.

Acclarent®
PART OF THE Johnson & Johnson FAMILY OF COMPANIES

TABLE OF CONTENTS

PATIENT SELECTION CRITERIA

BALLOON SINUPLASTY

Q. What is the appropriate patient selection criteria for Balloon Sinuplasty (BSP)?

A. Acclarent does not recommend specific patient selection criteria for BSP, also known as balloon sinus ostial dilation. Many health plans have adopted similar criteria as identified in the Humana medical policy shown below:

Example:
Humana Medical Policy: Policy Number: HCS-0309-022, revised, Effective Date 04/01/2021

Humana members may be **eligible under the Plan for balloon sinus ostial dilation when the following criteria are met:**

- Age 18 years or older; **AND**
- Balloon dilation is limited to the frontal, maxillary and/or sphenoid sinuses; **AND**
- Documentation of chronic rhinosinusitis for greater than 12 consecutive weeks OR documentation of recurrent acute rhinosinusitis (four or more occurrences in one year) and all of the following:
- Documented failure of medical therapy demonstrated by persistent upper respiratory symptoms despite therapy consisting of the following:
  - A minimum of two completed courses of different antibiotics; **AND**
  - A trial of at least six consecutive weeks using a steroid nasal spray (eg, Nasonex, Veramyst); **AND**
  - Allergy evaluation and treatment **if**:
    - Documented diagnosis of allergic rhinitis; **AND**
    - **Symptoms have not responded to appropriate environmental controls, antihistamine nasal spray (eg, Astepro, Patanase) and/or allergen immunotherapy (eg, injections)** (For information regarding coverage determination/limitations, please refer to Allergy Testing and Allergy Treatment Medical Coverage Policies); **AND**
  - Nasal saline irrigations for at least six consecutive weeks; **AND**
- Radiographic confirmation following the above mentioned treatments which demonstrates objective evidence* of:
  - Infection/sinusitis of the affected sinus(es); **OR**
  - Obstruction within the affected sinus(es); **OR**
  - Surrounding anatomy contributing to obstruction of the affected sinus(es)
- Balloon sinus ostial dilation used adjunctively during functional endoscopic sinus surgery (FESS) in the same sinus cavity is considered integral to the primary procedure and not separately reimbursable.

EUSTACHIAN TUBE BALLOON DILATION

Q. What are the appropriate patient selection criteria for Eustachian tube balloon dilation (ETBD)?

A. Acclarent does not recommend specific patient selection criteria for ETBD, also known as balloon dilation of the Eustachian tube (BDET), but supports the patient criteria currently outlined in many health plan coverage policies and the American Academy of Otolaryngology's 2019 BDET Clinical Consensus Statement.[1] Acclarent's intention is to promote appropriate, evidence-based care of patients with chronic obstructive eustachian tube dysfunction (OETD) for whom ETBD is being considered. The sample patient criteria below is provided as a reference only and does not constitute medical advice or medical care. Treating health care providers are solely responsible for diagnosis, treatment, and medical advice. Many health plans have adopted similar criteria as identified in the Blue Cross Blue Shield Tennessee (BCBS TN) medical policy:

EXAMPLE:

BCBS TN Medical Policy: Balloon Dilation of the Eustachian Tube, revised, Effective Date 8/12/2021

Balloon dilation of the eustachian tube (BDET) is considered medically appropriate if ALL of the following are met:

- Adult 18 years old or older
- Symptoms of chronic obstructive eustachian tube dysfunction (e.g., otalgia, hearing loss) including ALL of the following:
  - Aural fullness
  - Aural pressure
  - Symptoms lasting 3 months or longer that are continuous and not episodic (e.g.,symptoms occur only in response to barochallenge such as pressure changes while flying)
  - Condition significantly affects quality of life or functional health status
- Documentation of ALL of the following:
  - Nasal endoscopy
  - Tympanometry
  - Comprehensive audiometry, with ALL the following findings:
    - Abnormal tympanogram (Type B or C)
    - Abnormal tympanic membrane (retracted membrane, effusion, perforation, or any other abnormality identified on exam);
- Failure to respond to appropriate medical management of coexisting conditions (e.g.,allergic rhinitis, rhinosinusitis, and laryngopharyngeal reflux)
- Other causes of aural fullness have been ruled out. (e.g., temporomandibular joint disorders, extrinsic obstruction of the eustachian tube, superior semicircular canal dehiscence, and endolymphatic hydrops)
- Absence of ALL the following:
  - Patulous eustachian tube dysfunction
  - Craniofacial syndrome (i.e., cleft palate)
  - Neoplasm causing extrinsic obstruction
  - History of radiation therapy to the nasopharynx
  - Enlarged adenoid pads
  - Nasopharyngeal mass
  - Neuromuscular disorders that lead to hypotonia/ineffective eustachian tube
  - Dynamic opening
- Documentation shows reversibility of eustachian tube dysfunction when individual performs valsalva maneuver. (e.g., popping ears)
- No previous history of having balloon dilation of the eustachian tube

[1] Tucci DL et al Clinical Consensus Statement: Balloon Dilation of the Eustachian Tube. Otolaryngol Head Neck Surg. 2019 Jul;161(1):6-17. doi: 10.1177/0194599819848423. Epub 2019 Jun 4

COVERAGE

BALLOON SINUPLASTY

BSP is often covered by Public and Commercial Payers. Coverage policies may differ for "stand-alone" and "hybrid" procedures with FESS. Contact the Acclarent Reimbursement Support Services for further details on coverage in your state.

Q. What medical criteria is required by Medicare for coverage of Balloon Sinuplasty?

A. Medicare does not have a National Coverage Determination for BSP. However, Medicare does allow coverage and payment for services considered medically reasonable and necessary. Coverage for BSP is subject to standard medical necessity guidelines, which should be supported by quality clinical notes. There are no pre-determination/prior authorization mechanisms with Medicare for BSP.

EUSTACHIAN TUBE BALLOON DILATION

Q. Do payers cover Eustachian tube balloon dilation procedures?

A. Commercial Payers: Coverage policies may differ from plan to plan. For coverage details, contact the patient's insurance plan directly.

Medicare: At this time, Medicare does not have a National Coverage Determination for ETBD procedures. Medicare allows coverage and payment for services considered medically necessary and reasonable. Coverage for ETBD is subject to standard medical necessity guidelines, which should be supported in patient medical records. There are no pre-determination/prior authorization mechanisms with Medicare for ETBD. Please refer to your individual Medicare Administrative Contractor's (MAC) coverage policies for more information.

Medicare Advantage Plans will most likely require prior-authorization of the ETBD procedure. Please consult the commercial plan directly for additional information. Coverage for ETBD is subject to standard medical necessity guidelines, which should be supported in patient medical records.

COMPUTER ASSISTED SURGICAL NAVIGATION

Q. Do payers cover computer assisted surgical navigation?

A. Commercial Payers: Coverage policies may differ from plan to plan. For coverage details, contact the patient's insurance plan directly.

Medicare: Medicare does not have a National Coverage Determination or any Local Coverage Determinations for Computer Assisted Surgical Navigation, however, Medicare does allow coverage and payment for services considered medically easonable and necessary. CPT® code 61782 is found in the Medicare Physician Fee Schedule (MPFS found at: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx.)

RELIEVA TRACT™ NASAL DILATION SYSTEM

Q. Can a balloon be used to perform septoplasty?

A. The CPT® code for septoplasty is:

30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

The RELIEVA TRACT™ Nasal Dilation System is an instrument intended to provide increased intranasal space to facilitate access for endonasal and transnasal procedures and/or temporarily address nasal obstruction by displacing the inferior turbinate and lower nasal septum. When TRACT™ is used to access the sinus, the CPT® code for the primary surgical procedure should be coded. In this instance, CPT® code 30520 is used to report the septoplasty being performed via TRACT™ access. When TRACT™ is being used to displace tissue for nasal obstruction and no traditional instrumentation is used, CPT® code 30999 (Unlisted procedure, nose) may be reported.

Q. Why would a surgeon not be able to use the septoplasty code 30520 if only the TRACT™ is used?

A. The definition of 30520 indicates an incisional technique, with submucosal approach / access as an integral part of the repair. Therefore, to report with 30520 in absence of traditional instrumentation would be an overstatement of the procedure.

Q. Could the surgeon report 30520 with modifier 52 (reduced services)?

A. CPT® code 30999 (Unlisted procedure, nose) is more appropriate to report as TRACT™ does not meet the intent of 30520 for permanent definitive treatment. It should be noted, the RELIEVA TRACT™ Nasal Dilation System is a tool to temporarily address nasal obstruction or for access to the nasal anatomy, and is not intended or approved for definitive treatment.

The instructions in the Introduction of CPT® state, "Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code." Therefore, reporting of 30520 with modifier 52 is not accurate, as it does not match the descriptor for code 30520.

Q. How are claims submitted with an unlisted procedure code, when no specific CPT® code exists?

A. Providers should submit supporting documentation to the payor to accurately describe the work and resources associated with the procedure. The operative report is a key source of information and should include the following:

- Level of difficulty of the case
- Patient's diagnosis and duration of medical condition,.
- Risk of complication associated with the procedure.
- Anything unusual found during the procedure.

Additionally, include a cover letter which explains no specific CPT® code is currently available for this procedure and, therefore, the unlisted code was used. An established procedure code may be referenced which is comparable in time, skill, and work to the procedure performed to assist the payor in determining appropriate reimbursement. Submit the claim with a brief explanation, including why the comparative code is similar.

PRIOR APPROVAL / AUTHORIZATION

BALLOON SINUPLASTY (BSP)

Q. What steps should I take to get prior approval for Balloon Sinuplasty?

A. Prior to scheduling a BSP procedure, contact the patient's health plan to request a pre-determination of services. This means you are checking if prior authorization or pre-certification is required, and verifying BSP is a covered benefit *(use Acclarent Reimbursement prior authorization templates, which can be obtained through our Reimbursement Support Services)*.

If the pre-determination request is denied:

- File a Level 1 appeal with the health plan (*use Acclarent Appeal Template*) or request a peer-to-peer with the Medical Director.
- If your patient's health plan is self-funded, you can ask the patient to contact the claims administrator/HR representative at their employer and request approval for the procedure.

If the Level 1 appeal is denied:

- File a Level 2 appeal (if available) with the health plan *(use Acclarent Appeal Template)*.

If the Level 2 appeal is denied, or a Level 2 appeal is not available, you should request an external review

- According to provisions in the Affordable Care Act, the health plan is required to offer the external review option.

EUSTACHIAN TUBE BALLOON DILATION (ETBD)

Q. Do payers require prior-authorization for ETBD procedures?

A. Commercial: Coverage for ETBD procedures depends upon the insurance company. Prior to scheduling the procedure, the provider should contact the patient's health plan to inquire if a prior-authorization is required for ETBD procedures. A Letter of Medical Necessity (LOMN) may be submitted to the payer detailing the ETBD procedure and medical necessity for the patient.

Medicare: Medicare does not provide prior authorization, prior approval or predetermination of benefits for ETBD. General coverage guidelines for many services can be found using the Medicare Coverage Database. The database is maintained by CMS and is located on their web site at https://www.cms.gov/medicare-coverage-database/new-search/search.aspx. In the absence of a local or national coverage determination, the local MAC or carrier will determine whether coverage is available for a service on a case-by-case basis.

HMO/Medicare Advantage programs will most likely require prior-authorization of the ETBD procedure.

Q. What if my prior-authorization request is denied?

A. Prior-authorization may be denied because the payer could not determine the medical necessity and appropriateness of the proposed treatment, or the services are deemed experimental/investigational. Most payers will have their own appeals process and guidelines and will vary in their timelines and number of appeals that may be requested.

Contact the Acclarent Reimbursement Support Services to obtain template letters

PLACE OF SERVICE

Q. Does payment for sinus surgery depend on the Place of Service (POS)?

A. Yes, payment is different depending on the POS, and the appropriate POS code should be noted.

Physician office settings are defined as locations where health professionals "routinely provide health examinations, diagnosis and treatment of illness or injury on an ambulatory basis." Specifically excluded are hospitals, skilled nursing facilities, military treatment facilities and intermediate care facilities.

Place of Service Codes

CATEGORY	TYPE	PLACE OF SERVICE (POS) CODE
Facility	Inpatient Hospital	21
Facility	Outpatient Hospital	22
Facility	Ambulatory Surgery Center	24
Non- Facility	Physician Office	11

CODING

NASAL / SINUS ENDOSCOPIC SURGERY CODES

SINUS	CPT® CODE	DESCRIPTOR
FESS		
Ethmoid	31254	Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)
	31255	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)
Ethmoid / Frontal	31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed
Ethmoid / Sphenoid	31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoid-otomy
	31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoid-otomy, with removal of tissue from the sphenoid sinus
Maxillary	31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;
	31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
Frontal	31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration; with or without removal of tissue from frontal sinus
Sphenoid	31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;
	31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
BALLOON SINUPLASTY		
Maxillary	31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa
Frontal	31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium
Sphenoid	31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium
Frontal/ Sphenoid	31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia

Additional information regarding the nasal / sinus endoscopic surgery codes:

- Balloon-only CPT® codes may be reported in conjunction with traditional FESS CPT® codes for separate sinuses in a common procedure.
- Balloon-only CPT® codes may not be reported in conjunction with traditional FESS CPT® codes in a single sinus.
- Per American Academy of Otolaryngology – Head and Neck Surgery (AAO-HNS) coding guidelines, the use of balloon catheter tools may be coded with traditional FESS CPT® codes when
  1. Balloon catheter instruments are used in conjunction with other tools and
  2. Tissue is removed as part of intervention on that sinus.

Q. What is a stand-alone vs. a hybrid procedure and how does the coding differ?

A. ***A stand-alone procedure*** is the utilization of a balloon or other device used to dilate a sinus ostium under endoscopic visualization when no tissue is removed. The appropriate coding for a standalone procedure is to use one or more of the balloon dilation codes (31295, 31296, 31297, 31298).

A hybrid procedure is the utilization of a balloon as an adjunct tool during a FESS procedure to establish a pathway through the frontal recess to the frontal sinus followed by tissue removal (mucosa, polyps, scar, tumor and/or bony partitions) with traditional instrumentation such as forceps and/or the microdebrider. When the result is a frontal sinusotomy and tissue has been removed, the appropriate code is 31276 and the dilation is not separately reported. Similar rationale would apply to surgery involving the maxillary and sphenoid sinuses.

When the balloon is used as part of a FESS procedure, it is not separately paid, but included in the payment of the FESS procedure.

Acclarent defers to the guidance published by AAO-HNS found here (log in credentials required):

http://www.entnet.org/Practice/Coding-for-Balloon-Sinus-Dilation-2010.cfm

Q. What are the relevant ICD-10 diagnosis codes?

A. The following table lists the ICD-10 codes.

ICD-10-CM DIAGNOSIS CODES			
ICD-10		**ICD-10**	
J32.0	Chronic Maxillary Sinusitis	J01.01	Acute Recurrent Maxillary Sinusitis
J32.1	Chronic Frontal Sinusitis	J01.11	Acute Recurrent Frontal Sinusitis
J32.2	Chronic Ethmoidal Sinusitis	J01.21	Acute Recurrent Ethmoidal Sinusitis
J32.3	Chronic Sphenoidal Sinusitis	J01.31	Acute Recurrent Sphenoidal Sinusitis
J32.4	Chronic pansinusitis	J01.41	Acute Recurrent Pansinusitis
J32.8	Other chronic sinusitis	J01.81	Other Acute Recurrent Sinusitis
J32.9	Chronic sinusitis, unspecified	J01.91	Acute Recurrent Sinusitus Unspecified

EUSTACHIAN TUBE BALLOON DILATION

Q. What code should physicians use to report the ETBD procedure?

A. Beginning January 1, 2021, new Category 1 CPT® codes were introduced for this procedure:

69705 Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral

69706 Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral

Q. Why are there two codes for ETBD?

A. There were two codes established, one for unilateral procedures and the second for bilateral procedures. The payment for the two codes reflects the additional work the physician performs in a bilateral procedure.

Q. Is there a global period associated with 69705 or 69706?

A. There is no global period associated with 69705 or 69706.

Q. What are the Work RVUs assigned to CPT® 69705 and 69706?

A. CPT® 69705 = 3.00 Work RVUs and CPT® 69706 = 4.27 Work RVUs.

Q. What is the physician reimbursement for 69705 and 69706?

A. The Medicare program has assigned the following relative value units (RVUs) to these codes for 2022, with national average allowables (not geographically adjusted) shown

	CPT® CODES AND ASSIGNED RVUS			ALLOWABLES	
CODE	**WORK**	**TOTAL NON-FAC**	**TOTAL FACILITY**	**NON-FACILITY**	**FACILITY**
69705	3.00	85.01	5.11	$2,942	$177
69706	4.27	87.75	7.14	$3,037	$247

Q. What code should facilities use to report the ETBD procedure?

A. The same two CPT codes, 69705 or 69706, are appropriate for reporting by the outpatient facility (hospital outpatient or ambulatory surgery center).

Q. What is a C-Code?

A. Level II HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT® Code Set. HCPCS C codes are reported for device categories, novel technology procedures, drugs, biologicals and radiopharmaceuticals that do not have other HCPCS code assignments. Key points regarding C codes include the following:

- Applicable for Outpatient Hospital and ASC use only, physicians do not report C codes.
- Unique temporary pricing codes established by CMS for the Outpatient Prospective Payment System (OPPS).
- May be reported by facilities to Medicare and other payers utilizing the OPPS payment methodology; some commercial plans may also accept C codes.
- Not the same as Category III CPT® codes.

Q. What are the relevant ICD-10 diagnosis codes for Eustachian tube balloon dilation?

A. The following table lists the relevant ICD-10-CM codes for ETBD.

ICD-10-CM DIAGNOSIS CODES	
CODE	
H69.80	Other Specified Disorders of Eustachian Tube, Unspecified Ear
H69.81	Other Specified Disorders of Eustachian Tube, Right Ear
H69.82	Other Specified Disorders of Eustachian Tube, Left Ear
H69.83	Other Specified Disorders of Eustachian Tube, Bilateral

Q. Can I report Eustachian tube balloon dilation with concomitant procedures?

A. The Centers for Medicare and Medicaid Services (CMS) created the National Correct Coding Initiative (NCCI) to control improper coding that would lead to inappropriate payment by Medicare. It is an automated edit system to control specific CPT code pairs reported on the same day of service. The NCCI edits apply to all physician payments (in all settings), as well as the Ambulatory Surgery Center and Hospital Outpatient facility payment.

The 2021 edits bundled ETBD codes 69705 and 69706 with a large number of procedural codes. Performing any combination of these procedures on the same date of service resulted in the inability to report, and subsequently receive payment for, ETBD. In the January 2022 update, NCCI has revised or deleted a number of edits impacting ETBD.

When a Modifier MAY Be Used: In some instances, a modifier may be used to indicate an exception is appropriate. For example, if a surgeon determines that ETBD, in combination with BSP and/or FESS, is medically necessary, they can now complete the surgery on the same date of service and attach a modifier -59 to report a separate procedure. A modifier would be required if the primary procedure reported was*:

30801 or 30802 (ablation of inferior turbinates);

31233 – 31298 (FESS and BSP procedures);

31510 – 31546, 31560 – 31579 (surgical laryngoscopy procedures).

When a Modifier MAY NOT Be Used: There are still instances where the edits continue to bundle ETBD (69705 or 69706) with several other procedures. They may not be reported with*:

31231 (nasal endoscopy) or 92511 (nasopharyngoscopy with endoscope), as nasopharyngoscopy is an inherent component;

92502 (otolaryngologic exam under general anesthesia);

69990 (use of operating microscope);

Each other, as unilateral versus bilateral services are mutually exclusive.

DELETED NCCI Edits: Many edits were deleted, including*:

69209, 69210, and G0268 (removal of impacted cerumen);

69424 (ventilating tube removal requiring general anesthesia);

69433, 69436, or 0583T (tympanostomy, requiring insertion of ventilating tube);

Most other surgical procedures on the middle or inner ear.

*This is not an all-inclusive list of NCCI edits, or of the 2022 revisions and deletions to the NCCI.

Review the most current NCCI procedure-to-procedure (PTP) tables, as well as the NCCI Policy Manual, for additional information. The PTP tables are updated quarterly at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd. Report the appropriate CPT® code(s) for other procedures performed during the same operative session as ETBD.

COMPUTER ASSISTED SURGICAL NAVIGATION

Q. What code should physicians use to report computer assisted surgical navigation?

A. Computer assisted surgical navigation should be reported with the add-on code +61782. The code should be reported as an add on to the main surgical procedure. CPT code 61782 is reported once per surgical session, regardless of the number of sinuses involved.

MODIFIERS

EXAMPLES OF COMMONLY USED CPT® / HCPCS MODIFIERS	
MODIFIER	**TYPE**
50	Bilateral Procedure: When bilateral procedures are performed in the same session, append the additional procedure. 50% payment reduction of the second procedure generally applies for commercial plans. Medicare applies the special multiple endoscopy rules to nasal/sinus endoscopic procedures.
51	Multiple Procedures: When multiple procedures, other than E/M Services are performed at the same session by the same provider, append the additional procedure or service code(s). Use of 51 is not required by all payers.
53	Discontinued Procedure: Under certain circumstances, the physician may elect to terminate the procedure.
59	Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.
73	Discontinued Outpatient Hospital/Ambulatory Surgery (ASC) Procedure PRIOR TO the Administration of Anesthesia – Applied when extenuating circumstances require the cancellation of a procedure.
74	Discontinued Outpatient Hospital/Ambulatory Surgery (ASC) Procedure AFTER Administration of Anesthesia – Applies when extenuating circumstances require the cancellation of a procedure.
RT LT	Right Side: Used to identify procedures performed on the right side of the body. Left Side: Used to identify procedures performed on the left side of the body.

BALLOON SINUPLASTY

Q. Do multiple procedure reduction rules apply to sinus surgery codes?

A. Yes, the multiple procedure reduction rule applies to all sinus surgery codes. Medicare requires the use of modifier 51 to report multiple procedures.

The Physician Fee Schedule reimbursement calculation method for multiple procedures is now determined according to the multiple endoscopy rules. Special rules for multiple endoscopic procedures apply if a procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). For all FESS procedures, the base procedure is 31231. The highest fee schedule procedure is allowed in full; for the second and subsequent procedures, the MAC will subtract the base code allowable and pay the difference.

Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.

If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining procedures, and then apply the appropriate multiple surgery reductions. Since the base code, 31231, is defined as either unilateral or bilateral, it is not multiplied by 150% before being subtracted from the surgical endoscopy code(s), whether they are reported as bilateral or unilateral.

Q. Do I need to use a modifier to note bilateral procedures?

A. Yes, all sinus surgery codes are unilateral. Most payers require the use of modifier 50 for bilateral procedures. Payment for a bilateral procedure is typically calculated at 150%. Payment rules for multiple bilateral procedures vary by payor. For Medicare, if the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.

Q. What is the appropriate way to code for multiple bilateral procedures for Medicare patients?

A. Medicare requires the use of Modifier 50 to describe bilateral procedures. Although claims for bilateral procedures may be submitted with the RT/LT modifiers, the payment methodology will be the same. The CPT® code should be listed on one line, as one unit, and appended with Modifiers 50 and 51 as appropriate.

Example: The physician performs bilateral Balloon Sinuplasty procedures on the frontal, maxillary and sphenoid sinuses. Coding for the procedure would be as follows:

31295-50

31298-50-51

Commercial plans do not necessarily follow Medicare's guidelines. It is important to check with each payer to understand their coding requirements.

Q. The physician was unable to complete the balloon procedure. How should this be billed?

A. As defined in CPT®, under certain circumstances, the physician may elect to terminate a surgical procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical procedure was started but discontinued. This circumstance may be reported by adding Modifier 53 to the code for the discontinued procedure.

Modifier 53 can be billed once per operative session and is typically reimbursed approximately 50% of the allowed amount, although it is carrier priced. If the physician completes a FESS or BSP procedure on one sinus, but discontinues the procedure on a different sinus, only the single line item for the discontinued procedure is reported with modifier 53; the completed procedure is reported without modifier 53.

Modifier 53 can be used with Balloon Sinuplasty cases taking place In-Office cases or the Operating Room as long as it is not used "to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite."

The surgeon should keep a detailed account of the procedure, such as the operative note, as payers frequently request supporting documentation when reviewing a claim with Modifier 53.

EUSTACHIAN TUBE BALLOON DILATION

Q. Are the Eustachian tube balloon dilation codes also subject to the special multiple endoscopy rules in 2022?

A. Yes, the new CPT® ETBD procedure codes 69705 and 69706 are also subject to the Medicare multiple endoscopy special rules, with code 31231 identified as the base procedure.

Q. How do I report bilateral ETBD procedures?

A. Two distinct codes were introduced for 2021, describing either unilateral (69705) or bilateral (69706) ETBD. Therefore, code 69706 with no modifier captures a bilateral procedure.

PAYMENT

BALLOON SINUPLASTY

Q: Does non-facility payment include the cost of disposables?

A. Yes, the payment for procedures performed outside of the facility (in the office) is intended to cover all associated supply costs.

Q. Can I receive additional payment for performing lavage in conjunction with BSP or FESS?

A. No, National Correct Coding Initiative (NCCI) edits prohibit the billing of lavage with BSP or FESS when performed on the same sinus during the same operative session.

This formalizes the guidance issued by the AAO-HNS that FESS and BSP procedures are inclusive of lavage, and thus lavage should not be reported/billed separately when performed with those services.

LAVAGE CODES AND NCCI EDITS

LAVAGE CODES		DO NOT BILL WITH THE FOLLOWING CODES	
CPT® CODE	**DESCRIPTOR**	**CPT® CODE**	**DESCRIPTOR**
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	31233	Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)
		31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;
		31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
		31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa
31002	Lavage by cannulation; sphenoid sinus	31235	Nasal/sinus endoscopy, diagnostic; with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)
		31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy
		31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus
		31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy
		31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
		31297	Nasal/sinus endoscopy, surgical; with dilation (eg, balloon dilation); sphenoid sinus ostium
		31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia

Q: Do the BSP and FESS codes align to a Comprehensive Ambulatory Payment Classification (C-APC)?

A. Yes, the majority of the BSP and FESS codes are in C-APC 5155. Hospital reimbursement is the same regardless of the number of sinuses dilated, whether BSP or FESS is performed, and if concomitant procedures or navigation are added.

EUSTACHIAN TUBE BALLOON DILATION

Q. Did the introduction of new Category I CPT® codes in 2021 mean that ETBD is now reimbursed?

A. Achieving Cat I CPT® codes does not guarantee coverage or payment by any specific plan; these determinations are made by each payor. However, it is a very critical hurdle and a link between achieving optimal coverage and payment, as Category 1 CPT® Codes are established for procedures that have met the high threshold of documented clinical efficacy and broad medical practice adoption. Medicare has published allowed amounts for 69705 and 69706 in the 2022 Physician, Ambulatory Surgery Center, and Hospital Outpatient fee schedules. Commercial payers will make their own determinations. Please consult the commercial plan directly for additional information.

Q. What are the facility payment rates associated with 69705 and 69706?

A. 69705 and 69706 map to APC 5165 with a status indicator of J1 and an ASC payment indicator of J8. Please consult the Acclarent Physician and Facility Reimbursement Guide for Medicare national average payments.

Q. Do 69705 and 69706 align to a Comprehensive Ambulatory Payment Classification (C-APC)?

A. Yes, APC 5165 has a status indicator of J1, which means services are paid through a comprehensive APC. There is only one payment made to the hospital regardless of how many procedures are performed. If 69705 or 69706 is performed in conjunction with a BSP or FESS procedure, comprehensive APC 5165 will be assigned.

COMPUTER ASSISTED SURGICAL NAVIGATION

Q. What is the payment associated with computer assisted surgical navigation?

A. Physician: Physicians are paid the same in the office, hospital and ASC. Add-on codes are exempt from multiple procedure payment reduction, and so should be reimbursed at the full fee schedule amount identified by the payer.

Facility: 61782 has a status indicator of 'N' in the hospital outpatient setting and 'N1' in the ambulatory surgery center setting. Payment to the facility is packaged into payment for other services. There is no separate payment to the facility.

APPEALS

Q. My claim has been denied. How can I move forward with obtaining reimbursement?

A. If a claim or service is denied, an appeal may be filed with the insurance company. The reason for the denial can be found in the denial letter and/or the explanation of benefits (EOB).

An appeal letter should be tailored to the reason for the denial and may include a corrected claim, product information, patient medical information, clinical data, and/or economic data, along with other supporting documentation.

Submitting relevant medical documentation, which may support the medical necessity of the service(s) provided, is critical to the appeals process. The documents listed below are examples of the types of information, which may be submitted in order to support the claim for payment of the service:

- Patient medical records
- Treatment plan
- Physician's order
- Test results
- X-ray or CT Scan reports
- Operative report (detailed below)
- Product information
- Specific reasons why the physician believes the procedure is medically necessary
- Relevant clinical data
- List of failed conservative or alternative treatments
- Discharge notes

CODING RESOURCES AND REFERENCES

The following are some of the coding resources which are available to assist in accurately reporting Balloon Dilation services, procedures, and devices. These resources also informed the responses to the FAQs in this document.

ACCLARENT RESOURCES:

Reimbursement materials may be found at:
www.acclarent.com/tools-and-resource

For additional information please contact the Acclarent Reimbursement Suport Services at:

877.340.6466
or email us at
acclarentreimbursementsupport@its.jnj.com

OTHER RESOURCES:

AAO-HNS (American Academy of Otolaryngology – Head and Neck Surgery): **www.entnet.org**

ARS (American Rhinologic Society):
www.american-rhinologic.org

American Medical Association: **www.ama-assn.org**

- 2022 Current Procedural Terminology (CPT®), Professional Edition, ©2021 American Medical Association (AMA). All Rights Reserved
- American Medical Association Criteria for CPT® Category I and Category III codes. Updated 2021. Available online at: **www.ama-assn.org**
- CPT® Network: An online, subscription-based service for coding information: **www.cptnetwork.com**
- CPT® Assistant: A monthly coding publication of the American Medical Association
- ICD-10-CM 2022 Standard, Complete Official Codebook. AMA ©2021 (**www.cms.gov**) and is available from multiple publishers
- ICD-10-PCS 2022 Standard, Complete Official Codebook. AMA ©2021 (also at **www.cms.gov**) and is available from multiple publishers

Medicare Program website: **www.cms.gov**

- Provides a wide range of information and resources

Acclarent, Inc. Irvine, CA 92618 USA

Acclarent®
PART OF THE Johnson & Johnson FAMILY OF COMPANIES