2020 ACCLARENT REIMBURSEMENT GUIDE

Physician and Facility

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TABLE OF CONTENTS

This guide has been developed to assist you in obtaining physician and facility reimbursement for:

- Nasal/Sinus Endoscopic Surgery
- Eustachian Tube Balloon Dilation
- Airway Endoscopic Surgery
- Computer Assisted Surgical Navigation

These procedures may be a covered service if they meet all of the requirements established by Medicare and private payors. It is essential that each claim be coded properly and supported with appropriate documentation in the medical record.

FACILITY REIMBURSEMENT

NASAL/SINUS ENDOSCOPIC SURGERY

Some of the Current Procedure Terminology (CPT®) Codes for endoscopic nasal/sinus surgery are listed below. CPT® codes 31295, 31296, 31297 and 31298 apply to cases in which a balloon catheter is the only instrument/tool used to create the opening and no tissue is removed. When balloons are used in combination with other instruments/tools and tissue is removed, the existing endoscopic sinus surgery codes are the appropriate codes to report per the guidance of CPT® Assistant (January 2010/Volume 20, Issue 1). Endoscopic sinus surgery codes are unilateral, therefore modifier 50 should be used when billing for bilateral procedures.

CY 2020 FINAL HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER PAYMENT

		HOSPITAL OUTPATIENT (POS 22)			AMBULATORY SURGERY CENTER (POS 24)	
CPT®	**DESCRIPTION**	**APC**	**MEDICARE NATIONAL AVERAGE PAYMENT**	**SI**	**MEDICARE NATIONAL AVERAGE PAYMENT**	**PI**
30140	Submucous resection, inferior turbinate, partial or complete, any method	5164	$2,619	J1	$1,055	A2
30420	Rhinoplasty, primary; including major septal repair	5165	$4,850	J1	$2,247	A2
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	5164	$2,619	J1	$1,055	A2
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial	5163	$1,350	J1	$537	A2
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	5161	$204	T	$103	P2
31002	Lavage by cannulation; sphenoid sinus	5163	$1,350	J1	$537	R2
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	5151	$157	T	$79	P2
31233	Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	5152	$378	T	$191	A2
31235	Nasal/sinus endoscopy, diagnostic; with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)	5153	$1,430	J1	$612	A2
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	5153	$1,430	J1	$612	A2
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	5153	$1,430	J1	$612	A2
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	5154	$2,937	J1	$1,238	A2
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	5153	$1,430	J1	$612	A2
31241	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	5153	$1,430	J1	N/A - Excluded from coverage and payment in an ASC	N/A
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	5155	$5,440	J1	$1,896	A2
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	5155	$5,440	J1	$1,896	A2
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed	5155	$5,440	J1	$1,896	G2
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	5155	$5,440	J1	$1,896	G2

		HOSPITAL OUTPATIENT (POS 22)			AMBULATORY SURGERY CENTER (POS 24)	
CPT®	DESCRIPTION	APC	MEDICARE NATIONAL AVERAGE PAYMENT	SI	MEDICARE NATIONAL AVERAGE PAYMENT	PI
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	5155	$5,440	J1	$1,896	G2
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;	5154	$2,937	J1	$1,238	A2
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	5155	$5,440	J1	$1,896	A2
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, including removal of tissue from frontal sinus, when performed	5155	$5,440	J1	$1,896	A2
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;	5155	$5,440	J1	$1,896	A2
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	5155	$5,440	J1	$1,896	A2
31292	Nasal/sinus endoscopy, surgical, with orbital decompression; medial or inferior wall	5155	$5,440	J1	N/A - Excluded from coverage and payment in an ASC	N/A
31293	Nasal/sinus endoscopy, surgical, with orbital decompression; medial and inferior wall	5155	$5,440	J1	N/A - Excluded from coverage and payment in an ASC	N/A
31294	Nasal/sinus endoscopy, surgical, with optic nerve decompression	5155	$5,440	J1	N/A - Excluded from coverage and payment in an ASC	N/A
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	5155	$5,440	J1	$1,821	P3
31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	5155	$5,440	J1	$1,831	P3
31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium	5155	$5,440	J1	$1,817	P3
31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia	5155	$5,440	J1	$1,896	P2
42830	Adenoidectomy, primary; younger than age 12	5164	$2,619	J1	$1,055	A2
42831	Adenoidectomy, primary; age 12 or older	5164	$2,619	J1	$1,055	A2
42835	Adenoidectomy, secondary; younger than age 12	5164	$2,619	J1	$1,055	A2
42836	Adenoidectomy, secondary; age 12 or over	5164	$2,619	J1	$1,055	A2

OUTPATIENT HOSPITAL PAYMENT EXAMPLE

In this example, a patient undergoes a procedure including bilateral frontal sinus balloon dilation and bilateral maxillary sinus balloon dilation, either alone or in a hybrid FESS procedure.

BALLOON-ONLY PROCEDURE	HYBRID PROCEDURE	HOSPITAL OUTPATIENT (POS 22) 2020 MEDICARE PAYMENT	
CPT® CODES	**CPT® CODES**	**BALLOON ONLY**	**HYBRID**
31296-50 (APC 5155) Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	**31276-50 (APC 5155)** Nasal/sinus endoscopy, surgical with frontal sinus exploration, including removal of tissue from frontal sinus, when performed	APC 5155 (Level 5 Airway Endoscopy)	APC 5155 (Level 5 Airway Endoscopy)
31295-50-51 (APC 5155) Nasal/sinus endoscopy, surgical, with Dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	**31267–50-51 (APC 5155)** Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus		
Total Estimated Medicare Payment:		**$5,440**	**$5,440**

AMBULATORY SURGERY CENTER PAYMENT EXAMPLE

In this example, a patient undergoes a procedure including bilateral frontal sinus balloon dilation and bilateral maxillary sinus balloon dilation, either alone or in a hybrid FESS procedure.

BALLOON-ONLY PROCEDURE	HYBRID PROCEDURE	AMBULATORY SURGERY CENTER (POS 24) 2020 MEDICARE PAYMENT	
CPT® CODES	**CPT® CODES**	**BALLOON ONLY**	**HYBRID**
31296-50 Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	**31276-50** Nasal/sinus endoscopy, surgical with frontal sinus exploration, including removal of tissue from frontal sinus, when performed	$2,747	$2,844
		(Payment x Bilateral adjustment)	
31295-50-51 Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	**31267–50-51** Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	$1,366	$1,422
		(Payment x Bilateral adjustment x Multiple Procedure Reduction)	
Total Estimated Medicare Payment:		**$4,113**	**$4,266**

EUSTACHIAN TUBE BALLOON DILATION

Effective July 1, 2017 a HCPCS code has been established to describe a Eustachian Tube Balloon Dilation (ETBD) procedure with the ACCLARENT AERA® device. The C- Code, C9745 may be used by hospitals and ASCs. Physicians will continue to report the unlisted CPT® code for procedures of the middle ear. If concomitant procedures are performed during the same service, providers are to report the appropriate codes to describe the procedures performed.

CY 2020 FINAL HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTER PAYMENT

		HOSPITAL OUTPATIENT (POS 22)			AMBULATORY SURGERY CENTER (POS 24)	
CPT® CODE	**DESCRIPTION**	**APC**	**MEDICARE NATIONAL AVERAGE PAYMENT**	**SI**	**MEDICARE NATIONAL AVERAGE PAYMENT**	**PI**
69420	Myringotomy including aspiration and/or eustachian tube inflation	5161	$204	T	$103	P2
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	5164	$2,619	J1	$1,055	A2
69424	Ventilating tube removal requiring general anesthesia	5164	$2,619	Q2	$96	P3
69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia	5162	$442	T	$138	P3
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	5163	$1,349	J1	$537	A2
69501	Transmastoid antrotomy (simple mastoidectomy)	5165	$4,850	J1	$2,247	A2
69502	Mastoidectomy; complete	5165	$4,850	J1	$2,247	A2
69505	Mastoidectomy; modified radical	5165	$4,850	J1	$2,247	A2
69511	Mastoidectomy; radical	5165	$4,850	J1	$2,247	A2
69540	Excision aural polyp	5163	$1,349	J1	$159	P3
69610	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch	5163	$1,349	J1	$204	P3
69620	Myringoplasty (surgery confined to drumhead and donor area)	5164	$2,619	J1	$1,055	A2
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	5165	$4,850	J1	$2,247	A2
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	5165	$4,850	J1	$2,247	A2
69633	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])	5165	$4,850	J1	$2,247	A2
69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction	5165	$4,850	J1	$2,247	A2
69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction	5165	$4,850	J1	$2,247	A2

69637	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])	5165	$4,424	J1	$2,247	A2
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	5165	$4,850	J1	$2,247	A2
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	5165	$4,850	J1	$2,247	A2
69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction	5165	$4,850	J1	$2,247	A2
69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, with ossicular chain reconstruction	5165	$4,850	J1	$2,247	A2
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	5165	$4,850	J1	$2,247	A2
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	5165	$4,850	J1	$2,247	A2
69799	Unlisted procedure, middle ear	5161	$204	T	N/A – Excluded from coverage and payment in an ASC	N/A

CY 2020 FINAL HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTER PAYMENT (HCPCS CODE)

		HOSPITAL OUTPATIENT (POS 22)			AMBULATORY SURGERY CENTER (POS 24)	
CPT® CODE	**DESCRIPTION**	**APC**	**MEDICARE NATIONAL AVERAGE PAYMENT**	**SI**	**MEDICARE NATIONAL AVERAGE PAYMENT**	**PI**
C9745*	Nasal endoscopy, surgical; balloon dilation of eustachian tube	5165	$4,850	J1	$3,358	J8

*Applicable to Hospital Outpatient and ASC only. Physicians will continue to report the unlisted CPT® code for procedures of the middle ear.

AIRWAY ENDOSCOPIC SURGERY

CY 2020 FINAL HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER PAYMENT

		HOSPITAL OUTPATIENT (POS 22)			AMBULATORY SURGERY CENTER (POS 24)	
CPT® CODE	DESCRIPTION	APC	MEDICARE NATIONAL AVERAGE PAYMENT	SI	MEDICARE NATIONAL AVERAGE PAYMENT	PI
31526	Laryngoscopy direct, with or without tracheoscopy; diagnostic, with operating microscope or telescope	5153	$1,430	J1	$612	A2
31527	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator	5154	$2,937	J1	$1,238	A2
31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial	5154	$2,937	J1	$1,238	A2
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	5154	$2,937	J1	$1,238	A2
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope	5154	$2,937	J1	$1,238	A2
31615	Tracheobronchoscopy through established tracheostomy incision	5162	$442	T	$223	A2
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	5154	$2,937	J1	$1,238	A2
31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	5155	$5,440	J1	$1,896	A2
31641	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)	5154	$2,937	J1	$1,238	A2

COMPUTER ASSISTED SURGICAL NAVIGATION

CY 2020 FINAL HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER PAYMENT

		HOSPITAL OUTPATIENT (POS 22)			AMBULATORY SURGERY CENTER (POS 24)	
CPT® CODE	DESCRIPTION	APC	MEDICARE NATIONAL AVERAGE PAYMENT	SI	MEDICARE NATIONAL AVERAGE PAYMENT	PI
+61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural	N/A	$0	N	$0	N1

PHYSICIAN REIMBURSEMENT

NASAL/SINUS ENDOSCOPIC SURGERY

Some of the Current Procedure Terminology (CPT®) Codes for endoscopic nasal/sinus surgery are listed below. CPT® codes 31295, 31296, 31297 and 31298 apply to cases in which a balloon catheter is the only instrument/tool used to create the opening and no tissue is removed. When balloons are used in combination with other instruments/tools and tissue is removed, the existing endoscopic sinus surgery codes are the appropriate codes to report per the guidance of CPT® Assistant (January 2010/Volume 20, Issue1). Endoscopic sinus surgery codes are unilateral, therefore modifier 50 should be used when billing for bilateral procedures.

CY 2020 FINAL PHYSICIAN PAYMENT

			RELATIVE VALUE UNITS (RVUS)		MEDICARE NATIONAL AVERAGE PAYMENT	
CPT®	DESCRIPTION	GLOBAL	FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
30140	Submucous resection, inferior turbinate, partial or complete, any method	0	5.11	8.08	$185	$292
30420	Rhinoplasty, primary; including major septal repair	90	40.33	N/A	$1,455	N/A
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	90	18.44	N/A	$665	N/A
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial	10	4.10	6.18	$148	$223
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	10	3.02	5.17	$109	$187
31002	Lavage by cannulation; sphenoid sinus	10	5.39	N/A	$195	N/A
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	0	1.82	5.48	$66	$198
31233	Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	0	3.84	7.45	$139	$269
31235	Nasal/sinus endoscopy, diagnostic; with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)	0	4.54	8.49	$164	$306
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	0	4.54	7.21	$164	$260
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage	0	4.77	7.11	$172	$257
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	10	17.41	N/A	$628	N/A
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	0	4.52	N/A	$163	N/A
31241	Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	0	12.77	N/A	$461	N/A
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	0	6.98	11.99	$252	$433
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	0	9.31	N/A	$336	N/A
31253	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed	0	14.40	N/A	$520	N/A
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	0	12.82	N/A	$463	N/A

			RELATIVE VALUE UNITS (RVUS)		MEDICARE NATIONAL AVERAGE PAYMENT	
CPT®	DESCRIPTION	GLOBAL	FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	0	13.57	N/A	$490	N/A
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy	0	5.17	N/A	$187	N/A
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	0	7.61	N/A	$275	N/A
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, including removal of tissue from frontal sinus, when performed	0	10.86	N/A	$392	N/A
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy	0	5.78	N/A	$209	N/A
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	0	6.71	N/A	$242	N/A
31292	Nasal/sinus endoscopy, surgical, with orbital decompression; medial or inferior wall	10	28.42	N/A	$1,026	N/A
31293	Nasal/sinus endoscopy, surgical, with orbital decompression; medial and inferior wall	10	30.71	N/A	$1,108	N/A
31294	Nasal/sinus endoscopy, surgical, with optic nerve decompression	10	35.17	N/A	$1,269	N/A
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	0	4.52	53.54	$163	$1,932
31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	0	5.15	54.27	$186	$1,959
31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium	0	4.12	53.12	$149	$1,917
31298	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia	0	7.34	102.11	$265	$3,685
42830	Adenoidectomy, primary; younger than age 12	90	5.95	N/A	$215	N/A
42831	Adenoidectomy, primary; age 12 or older	90	6.44	N/A	$232	N/A
42831	Adenoidectomy, secondary; younger than age 12	90	5.51	N/A	$199	N/A
42836	Adenoidectomy, secondary; age 12 or over	90	6.89	N/A	$249	N/A

2020 Medicare Reimbursement Policy Changes:

The Physician Fee Schedule reimbursement calculation method for multiple procedures will now be determined according to the multiple endoscopy rules. Special rules for multiple endoscopic procedures apply if 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, subtract the base code allowable and pay the difference. 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.

PHYSICIAN PROFESSIONAL PAYMENT EXAMPLES

The following case examples are based upon the 2020 Medicare Physician Fee Schedule. In the first example, a patient undergoes a procedure including unilateral maxillary sinus balloon dilation and unilateral frontal sinus balloon dilation. The coding and national Medicare average payments reflect a procedure in which a balloon is the only tool used and no tissue is removed. Per AMA and AAO-HNSF guidance, when balloons are used as a tool in FESS and when tissue is removed, the traditional FESS codes should be used.

UNILATERAL PROCEDURES CPT® CODES	2020 MEDICARE NON-FACILITY PAYMENT (PHYSICIAN OFFICE - POS 11)*	2020 MEDICARE FACILITY PAYMENT (ASC - POS 24 OR HOSPITAL - POS 22)
31296 Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	$1,959 (100%)	$186 (100%)
31295-51 Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	$1,932 (100%) – $198 (31231) = $1,734	$163 (100%) – $66 (31231) = $97
Total Estimated Medicare Payment:	**$3,693**	**$283**

The second example shows the same procedures performed bilaterally.

BILATERAL PROEDURES CPT® CODES	2020 MEDICARE NON-FACILITY PAYMENT (PHYSICIAN OFFICE - POS 11)*	2020 MEDICARE FACILITY PAYMENT (ASC - POS 24 OR HOSPITAL - POS 22)
31296-50 Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	$1,959 x 150% = $2,939	$186 x 150% = $279
31295-50-51 Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	$1,932 x 150% = $2,898 – $198 (31231) = $2,700	$163 x 150% = $245 – $66 (31231) = $179
Total Estimated Medicare Payment:	**$5,639**	**$458**

*Non-facility payment includes the cost of disposables.

The third example shows a bilateral frontal balloon dilation, bilateral maxillary FESS, total ethmoidectomy, and sphenoid FESS.

CPT® CODES	2019 PHYSICIAN PAYMENT	2020 PHYSICIAN PAYMENT
	FACILITY	**FACILITY**
31259-50	$492 x 150% = $738	$490 x 150% = $735
31267-50-51	$276 x 150% = $414 x 50% = $207	$275 x 150% = $412 - $66 (31231) = $346
31296-50-51	$186 x 150% = $279 x 50% = $140	$186 x 150% = $279 - $66 (31231) = $213
Total Estimated Medicare Payment:	**$1,085**	**$1,294**

The fourth example shows a procedure including bilateral frontal balloon dilation, bilateral maxillary FESS, anterior ethmoidectomy, and sphenoid balloon dilation.

CPT® CODES	2019 PHYSICIAN PAYMENT	2020 PHYSICIAN PAYMENT
	FACILITY	FACILITY
31267-50	$276 x 150% = $414	$275 x 150% = $412
31254-50-51	$253 x 150% = $380 x 50% = $190	$252 x 150% = $378 - $66 (31231) = $312
31298-50-51	$266 x 150% = $399 x 50% = $199	$265 x 150% = $398 - $66 (31231) = $332
Total Estimated Medicare Payment:	**$803**	**$1,056**

EUSTACHIAN TUBE BALLOON DILATION

Currently no procedure-specific CPT® code exists to describe a Eustachian Tube Balloon Dilation (ETBD) procedure with the ACCLARENT AERA® device. Until the implementation of a procedure-specific CPT® code, providers are to report the unlisted CPT® code for procedures of the middle ear. If concomitant procedures are performed during the same service, providers are to report the appropriate codes to describe the procedures performed.

CY 2020 FINAL PHYSICIAN PAYMENT

			RELATIVE VALUE UNITS (RVUS)		MEDICARE NATIONAL AVERAGE PAYMENT	
CPT® CODE	DESCRIPTION	GLOBAL	FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
69420	Myringotomy including aspiration and/or eustachian tube inflation	10	3.39	5.31	$122	$192
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	10	4.21	N/A	$152	N/A
69424	Ventilating tube removal requiring general anesthesia	0	1.73	3.62	$62	$131
69433	Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia	10	3.72	5.62	$134	$203
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	10	4.48	N/A	$162	N/A
69501	Transmastoid antrotomy (simple mastoidectomy)	90	20.39	N/A	$736	N/A
69502	Mastoidectomy; complete	90	27.11	N/A	$978	N/A
69505	Mastoidectomy; modified radical	90	34.22	N/A	$1,235	N/A
69511	Mastoidectomy; radical	90	35.06	N/A	$1,265	N/A
69540	Excision aural polyp	10	3.58	5.83	$129	$210
69610	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch	10	8.24	10.75	$297	$388
69620	Myringoplasty (surgery confined to drumhead and donor area)	90	13.90	20.05	$502	$724
69631	Tympanoplasty without mastoidectomy, (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	90	25.09	N/A	$905	N/A
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	90	30.57	N/A	$1,103	N/A
69633	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])	90	29.62	N/A	$1,069	N/A
69635	Tympanoplasty with antrotomy or mastoidotomy; without ossicular chain reconstruction	90	35.09	N/A	$1,266	N/A
69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction	90	39.25	N/A	$1,417	N/A

69637	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis [PORP], total ossicular replacement prosthesis [TORP])	90	39.07	N/A	$1,410	N/A
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	90	29.55	N/A	$1,066	N/A
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	90	37.97	N/A	$1,370	N/A
69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction	90	34.69	N/A	$1,252	N/A
69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, with ossicular chain reconstruction	90	42.03	N/A	$1,517	N/A
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	90	41.36	N/A	$1,493	N/A
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	90	43.84	N/A	$1,582	N/A
69799	Unlisted procedure, middle ear	YYY*	N/A**	N/A**	At the discretion of the payor***	At the discretion of the payor***

* Contractor Priced
** Unlisted CPT codes have no RVUs assigned to them under the Medicare Physician Fee Schedule
*** Payment for unlisted codes is on a case-by-case basis. Contact the patient's health plan for verification of coverage and payment

Procedure reporting with unlisted CPT® codes:
To assist payors with processing claims for ETBD procedures, additional documentation may be required to support the unlisted CPT® code 69799. Since these codes are not procedure-specific, payors will need to understand the procedure performed and the clinical resources utilized. The documentation requested will vary by payor and may include the following to support the payment of the claim:

Describe the patient's diagnosis and how the procedure supports medical necessity
Describe the surgical technique to perform the surgery, including anesthesia and difficulty of the case
Submit the operative note highlighting when the ACCLARENT AERA® Eustachian Tube Balloon Dilation System was used for ETBD
Provide a comparable CPT® code for a procedure with similar resources and explain how the procedures are similar in time, skill, and resource utilization

AIRWAY ENDOSCOPIC SURGERY

CY 2020 FINAL PHYSICIAN PAYMENT

CPT® CODE	DESCRIPTION	GLOBAL DAYS	RELATIVE VALUE UNITS (RVUS)		MEDICARE NATIONAL AVERAGE PAYMENT	
			FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
31526	Laryngoscopy direct, with or without tracheoscopy; diagnostic, with operating microscope or telescope	0	4.46	N/A	$161	N/A
31527	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator	0	5.55	N/A	$200	N/A
31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial	0	4.09	N/A	$148	N/A
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	0	4.59	4.76	$166	$171
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope	0	7.52	N/A	$271	N/A
31615	Tracheobronchoscopy through established tracheostomy incision	0	3.28	4.88	$118	$176
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	0	5.72	N/A	$206	N/A
31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/ bronchial dilation as required)	0	6.56	N/A	$237	N/A
31641	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with destruction of tumor or relief of stenosis by any method other than excision (eg, laser therapy, cryotherapy)	0	7.37	N/A	$266	N/A

COMPUTER ASSISTED SURGICAL NAVIGATION

CY 2020 FINAL PHYSICIAN PAYMENT

CPT® CODE	DESCRIPTION	GLOBAL DAYS	RELATIVE VALUE UNITS (RVUS)		MEDICARE NATIONAL AVERAGE PAYMENT	
			FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
+61782*	Stereotactic computer-assisted (navigational) procedure; cranial, extradural	ZZZ**	5.01	N/A	$181	N/A

* 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.
** The code is related to another service and is always included in the Global Period of the primary service.

ICD-10 DIAGNOSIS CODES

ICD-10	DESCRIPTION
BALLOON SINUPLASTY	
J32.0	Chronic Maxillary Sinusitis
J32.1	Chronic Frontal Sinusitis
J32.2	Chronic Ethmoidal Sinusitis
J32.3	Chronic Sphenoidal Sinusitis
J32.4	Chronic Pansinusitis
J32.8	Other Chronic Sinusitis
J32.9	Chronic Sinusitis, Unspecified
EUSTACHIAN TUBE BALLOON DILATION (ETBD)	
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

MODIFIERS

MODIFIER	DESCRIPTION
50	**Bilateral Procedure:** When bilateral procedures are performed in the same session, append modifier 50 to the procedure. 50% payment reduction of the second procedure generally applies. Note: This modifier should not be appended to designated "add-on" codes.
51	**Multiple Procedures:** When multiple procedures, other than E/M Services, are performed at the same session by the same provider, append to the additional procedure or service code(s). 50% payment reduction of the second procedure generally applies, although Medicare applies a special endoscopic reimbursement methodology to certain codes. Use of modifier 51 is not required by all payors.
53	**Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate the procedure.
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.

NOTES

Acclarent, Inc. products are not used in all procedures listed. The most appropriate code for the patient's clinical presentation must be selected. CPT® copyright 2019 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to government use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Sources: Calendar Year 2020 Medicare Outpatient Prospective Payment System, Final Rule [CMS-1717-FC], Federal Register, November 12, 2019 and its associated addenda posted on the Centers for Medicare and Medicaid Services web site on November 1, 2019. Medicare payment allowable rates shown above do not reflect the automatic payment cuts required under the sequestration process of the 2011 Budget Control Act. Calendar Year 2020 Medicare Physician Fee Schedule, Final Rule [CMS-1715-F and IFC]. Federal Register, November 15, 2019. No geographic adjustments have been made to the reported payment rates. 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

STATUS INDICATOR (SI) DEFINITIONS: C - Inpatient only procedure; procedure not paid under OPPS **J1** - Hospital Part B services paid through a Comprehensive APC. **N** - Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. **Q2** - Payment is packaged if billed on the same date of service as a HCPCS code assigned a status indicator "T"; otherwise payment is made through a separate APC payment. **T** - Significant procedure, multiple procedure reduction applies.

PAYMENT INDICATOR (PI) DEFINITIONS: A2 - Surgical procedure on ASC list in CY 2007, payment based on OPPS relative payment weight; **G2** - Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight; **J8** - Device-intensive procedure added to

DISCLAIMER

The information contained in this guide is provided to assist you in understanding the reimbursement process. It is intended to assist providers in accurately obtaining reimbursement for health care services. It is not intended to increase or maximize reimbursement by any payer. We strongly suggest that you consult your payer organization with regard to local reimbursement policies.

The information contained in this document is provided for information purposes only and represents no statement, promise or guarantee by Acclarent concerning levels of reimbursement, payment or charge. Similarly, all CPT® and HCPCS codes are supplied for information purposes only and represent no statement promise or guarantee by Acclarent that these codes will be appropriate or that reimbursement will be made.

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