2020 FAQ
ACCLARENT CODING AND REIMBURSEMENT
Physician and Facility

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PATIENT SELECTION CRITERIA

BALLOON SINUPLASTY

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

A. Acclarent does not have recommended patient selection criteria, as we believe selection criteria for Balloon Sinuplasty (BSP) is the same as for Functional Endoscopic Sinus Surgery (FESS). Many health plans have adopted similar criteria as identified in the Humana medical policy:

Example: Humana Medical Policy (Policy Number: HCS-0309-017, Effective Date 02/26/2019)

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 or sphenoid sinuses; **AND**
- Documentation of chronic rhinosinusitis for greater than 12 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 different antibiotic courses; **AND**
        - A trial of steroid nasal spray (eg, Nasonex, Veramyst); **AND**
        - Allergy evaluation and treatment (if symptoms are consistent with allergic rhinitis and 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 irrigation; **AND**
    - Radiographic confirmation, of the affected sinus(es), showing objective evidence of sinusitis or obstructive anatomy (eg, air fluid levels, mucosal thickening or swelling, opacification, concha bullosa, pansinusitis, etc.)
- 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.

COVERAGE

BALLOON SINUPLASTY

Balloon Sinuplasty is often covered by Public and Commercial Payers. Coverage policies may differ for "stand-alone" and "hybrid" procedures. Contact the Acclarent Reimbursement Hotline 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 Balloon Sinuplasty, however does allow coverage and payment for services considered medically reasonable and necessary. Balloon Sinuplasty coverage by Medicare 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, and we are not aware of any denials of coverage. The CPT® codes 31295, 31296, 31297, 31298 are built into the Medicare Physician Fee Schedule (MPFS) found at: http://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx.

EUSTACHIAN TUBE BALLOON DILATION

Q. Do payers cover Eustachian tube balloon dilation (ETBD) 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. However, some Medicare Administrative Contractors (MACs) may have special coverage requirements since the procedure is reported by an unlisted code. A few MACs are developing proposed Local Coverage Determinations (LCDs) for future implementation. Please refer to your individual MACs 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 does allow coverage and payment for services considered medically reasonable and necessary. CPT® code 61782 is found in the Medicare Physician Fee Schedule (MPFS) found at: http://www.cms.gov/apps/physicianfee-schedule/license-agreement.aspx.

PRIOR APPROVAL / AUTHORIZATION

BALLOON SINUPLASTY

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

A. Prior to scheduling a Balloon Sinuplasty 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 Balloon Sinuplasty is a covered benefit *(use Acclarent Reimbursement Template #1 or #2)*.

If the pre-determination request is denied:

- File a Level 1 appeal with the health plan *(use Acclarent Appeal Template #3)* or request a peer-to-peer with the Medical Director *(use Bullet Points for Physician Advocacy)*
- Also, 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 *(patient can use Bullet Points for Patient Advocacy)*.

If the Level 1 appeal is denied:

- File a Level 2 appeal (if available) with the health plan *(use Acclarent Appeal Template #5)*.

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

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 any services. 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 http://www.cms.gov/medicare-coverage-database/overview-and-quick-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

Please contact the Acclarent Reimbursement Support Services at 1.877.340.6466, if you need assistance.

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 AAO-HNSF 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. At the present time, a procedure-specific CPT® code does not exist for ETBD. The procedure should be reported by an available unlisted CPT® code. **69799** Unlisted procedure of the middle ear

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

A. When facilities are billing Medicare for services, C9745 may be used to report the procedure. When billing private and commercial payers the unlisted CPT® code should be utilized.

C9745 Nasal endoscopy, surgical; balloon dilation of eustachian tube

69799 Unlisted procedure of the middle ear

C1726 and C1769 describe the Acclarent AERA® Eustachian Tube Balloon Dilation System and should also be reported.

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	
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. What is a C-Code?

A. Level ll 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 Hospital and ASC use only. Physicians will continue to report the unlisted code.
- Are 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. Facilities may continue to report the unlisted code with other payers, although some commercial plans may also accept C codes.
- Are not the same as Category III CPT® codes.

Q. When will a Category I CPT® code be implemented for this procedure?

A. The AMA's CPT® Editorial Panel has accepted the addition of two new Category 1 CPT® Codes for Eustachian Tube Balloon Dilation (ETBD). The AMA-established Category I CPT® Codes will provide standardized codes for physicians to report and bill for ETBD procedures. These codes will be effective January 1, 2021.

Q. What are the actual new CPT® codes?

A. The AMA has only released placeholder numbers at this time. Final CPT® codes are not assigned until mid-2020. Additionally, the code descriptions may be further refined prior to their implementation.

Q. Why are there two codes for ETBD?

A. A CPT® code for an in-office procedure includes payment for both the physician and practice expense. There were two codes established, one for unilateral procedures and the second for bilateral procedures. The payment for the two codes will reflect the additional work the physician performs in a bilateral procedure. More clarity will be available in mid-2020, when the final codes, their descriptors, and Medicare payments are released.

Q. Is there a global period associated with C9745?

A. There is no global period associated with C9745.

Q. Will C9745 still be used by facilities in 2021, after the new CPT codes are introduced?

A. It is likely that the new CPT® codes will replace C9745 in the Medicare ASC and Hospital Outpatient payment guidelines for 2021. However, this will be determined according to the Final Rules to be published in mid-2020. The device codes C1726 and C1769 may still be appropriate to report in conjunction with the procedure code.

Q. Can I report ETBD with concomitant procedures?

A. There are no defined National Correct Coding Initiative (NCCI) edits that prohibit the billing of the unlisted CPT® code 69799 or C9745 with other procedures. 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. 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. Beginning 2020, Medicare will apply 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.
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.

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.

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 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 In Office cases and OR cases as long as it's 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. Do multiple procedure reduction rules apply to the unlisted code?

A. Yes, the multiple procedure reduction rule applies to the unlisted surgery code 69799. Medicare requires the use of modifier 51 to report multiple procedures. Commercial guidelines vary.

Q. Are the Eustachian tube balloon dilation codes also subject to the special multiple endoscopy rules in 2020?

A. Since the ETBD procedures are reported with an unlisted procedure code, standard multiple procedure rules would apply for Medicare. Commercial guidelines are payer specific.

Q. How do I report bilateral procedures?

A. It is not appropriate to append modifiers to unlisted CPT® codes because the unlisted procedure codes in the CPT® codebook do not describe specific procedures. Instead, when reporting an unlisted code to describe a procedure or service, supporting documentation (eg, procedure report) should be submitted to provide an adequate description of the nature, extent, need for the procedure, time, effort, and equipment necessary to provide the service. If C9745 is used, a bilateral procedure may be reported using the modifiers RT or LT. Consult directly with the payer for specific guidelines.

PAYMENT

BALLOON SINUPLASTY

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

A. The payment for the procedure 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. As of April 1, 2014 there are official National Correct Coding Initiative (NCCI) edits that 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 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.

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.

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

While there isn't a code specific to frontal sinus lavage, it should also be considered bundled (i.e., do not report frontal lavage with 31299 (unlisted procedure, accessory sinuses) in combination with 31276 (FESS, frontal sinus) or 31296 (BSP, frontal sinus ostium).

EUSTACHIAN TUBE BALLOON DILATION

Q. Since the unlisted code does not have an established payment value, how will the ETBD procedure be paid?

A. Payment for procedures reported with an unlisted code is at the discretion of the payer. Providers should submit supporting documentation to the payer to accurately describe the work and resources associated with the procedure. The operative report is a key source of information and should include information such as the following:

- Level of difficulty of the case
- Patient's diagnosis and duration of medical condition
- Risk of complication associated with the procedure
- Resources required to perform the procedure
- Anything unusual found during the procedure
- Other problems the patient is having and associated follow up care

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 can be referenced, which is comparable in time, skill, and work to the ETBD procedure. Submit the claim with a brief explanation, including why the comparator CPT® code is similar to ETBD.

Be advised payers have their own guidelines for reviewing/adjudicating claims with unlisted codes. Check with your payer to inquire about individual requirements.

Q. Does 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.

Q. What is the payment rate associated with C9745?

A. C9745 maps to APC 5165 with a status indicator of J1 and an ASC payment indicator of J8. Please consult the Acclarent Reimbursement Guide Physician and Facility for Medicare national average payments.

Q. Does C9745 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.

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 Sinuplasty services, procedures, and devices. These resources also informed the responses to the FAQs in this document.

ACCLARENT RESOURCES:

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

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

877.340.6466
or email us at
acclarent.reimbursement@milestonecro.com

OTHER RESOURCES:

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

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

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

- 2020 Current Procedural Terminology (CPT®), Professional Edition, ©2019 American Medical Association (AMA). All Rights Reserved
- American Medical Association Criteria for CPT® Category I and Category III codes. Updated 2019. Available online at: **https://www.ama-assn.org/practice- management/cpt/criteria-cpt-category-i-and-category-iii-codes.**
- 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 2020 Standard, Complete Official Codebook. AMA ©2019 (**www.nchs.cdc.gov**) and is available from multiple publishers
- ICD-10-PCS 2020 Standard, Complete Official Codebook. AMA ©2019 (**www.cms.gov**) and is available from multiple publishers

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

- Provides a wide range of information and resources

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