2020 ACCLARENT ENT MEDICARE UPDATES

The following tables reflect the CY2020 Medicare national average fee schedules for Physician, Hospital Outpatient and Ambulatory Surgical Centers, for Airway Dilation, Balloon Sinuplasty (BSP), Eustachian Tube Balloon Dilation (ETBD), and Navigation procedures.

2020 MEDICARE NATIONAL AVERAGE PHYSICIAN PAYMENTS

CPT® CODES	DESCRIPTION	2019 FACILITY PAYMENT[1]	2020 FACILITY PAYMENT[2]	2019-2020 % CHANGE IN FACILITY PAYMENT	2019 NON-FACILITY PAYMENT[1]	2020 NON-FACILITY PAYMENT[2]	2019-2020 % CHANGE IN NON-FACILITY PAYMENT
31295	Nasal/sinus endoscopy, surgical, with dilation (e.g. balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	$164	$163	-0.5%	$2,005	$1,932	-3.6%
31296	Nasal/sinus endoscopy, surgical, with dilation (e.g. balloon dilation); frontal sinus ostium	$186	$186	-0.2%	$2,031	$1,959	-3.6%
31297	Nasal/sinus endoscopy, surgical, with dilation (e.g. balloon dilation); sphenoid sinus ostium	$149	$149	-0.3%	$1.990	$1,917	-3.7%
31298	Nasal/sinus endoscopy, surgical, with dilation (e.g. balloon dilation); frontal and sphenoid sinus ostia	$266	$265	-0.3%	$3,842	$3,685	-4.1%
31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial	$149	$148	-0.8%	N/A	N/A	N/A
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	$167	$166	-0.5%	N/A	N/A	N/A
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/ bronchial dilation or closed reduction of fracture	$206	$206	0.3%	N/A	N/A	N/A
31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	$237	$237	-0.2%	N/A	N/A	N/A
61782	Stereotactic (computer-assisted) navigation procedure; cranial, extradural	$181	$181	-0.1%	N/A	N/A	N/A

2020 HOSPITAL OUTPATIENT MEDICARE NATIONAL AVERAGE PAYMENTS

APC	DESCRIPTION	2019 PAYMENT[3]	2020 PAYMENT[4]	2019-2020 % CHANGE IN PAYMENT
5154	Level 4 Airway Endoscopy: Includes Airway dilation procedures	$2,741	$2,937	7.1%
5155	Level 5 Airway Endoscopy: Includes BSP and FESS	$5,148	$5,440	5.7%
5165	Level 5 ENT Procedures: Includes C9745 (ETBD)	$4,424	$4,850	9.6%

No additional Hospital reimbursement for the use of navigation. Navigation is considered inclusive to the primary procedure.

2020 AMBULATORY SURGICAL CENTER MEDICARE NATIONAL AVERAGE PAYMENTS

CPT® CODES	DESCRIPTION	2019 PAYMENT[3]	2020 PAYMENT[4]	2019-2020 % CHANGE IN PAYMENT
31253-31298*	BSP and FESS	$1,791	$1,896	5.9%
C9745	ETBD	$3,061	$3,358	9.7%
31528, 31529, 31630	Airway Dilation	$1,180	$1,238	4.9%
31631	Airway Dilation	$1,791	$1,896	5.9%

No additional ASC reimbursement for the use of navigation. Navigation is considered inclusive to the primary procedure.
*31254 will increase 4.9% (from $1,180 to $1,238). Single sinus BSP codes have a status change to P3 – all were previously allowed at $1,791; for 2020, 31295 will increase 1.7% to $1,821, 32196 will increase 2.3% to $1,831, and 31297 will increase 1.5% to $1.817. 31298 remains the same allowable as most FESS procedures.

2020 Medicare Reimbursement Policy Changes[1]:

Multiple Endoscopy Rules[1]: 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.

Medicare Promotion of Evidence-Based Care for Advanced Diagnostic Imaging (for services ordered on or after January 1, 2020):

Ordering Professionals must consult appropriate use criteria (AUC) through qualified Clinical Decision Support Mechanisms (CDSMs) for applicable imaging services under specified settings and payment systems. Ordering Professionals must consult appropriate use criteria (AUC) through qualified Clinical Decision Support Mechanisms (CDSMs) for applicable imaging services under specified settings and payment systems, and provide relevant information to the furnishing professional.

Furnishing Professionals must report the information on Medicare claims for advanced diagnostic imaging services. The requirement to consult an AUC is in an educational and operations testing process during 2020, so no denials should be experienced for errors; claims impact could be expected beginning in 2021.

Additional information may be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.

Sources:

[1] CMS-1693-F Medicare Physician Fee Schedule (MPFS) Final Rule CY 2019
[2] CMS-1715-F and IFC Medicare Physician Fee Schedule (MPFS) Final Rule CY 2020
[3] CMS-1695-FC Hospital Outpatient Prospective Payment System CY 2019 Payment Rates
[4] CMS-1717-FC Hospital Outpatient Prospective Payment System CY 2020 Payment Rates

BALLOON SINUPLASTY CODING AND MEDICARE NATIONAL AVERAGE PAYMENT EXAMPLES

EXAMPLE #1

In this example, a patient undergoes a procedure including unilateral frontal sinus balloon dilation, unilateral maxillary sinus balloon dilation, and unilateral sphenoid dilation performed without a FESS procedure.

	2019 PHYSICIAN PAYMENT		2020 PHYSICIAN PAYMENT	
CPT® CODES	**OFFICE**	**FACILITY**	**OFFICE**	**FACILITY**
31298	$3,842 (100%)	$266 (100%)	$3,685 (100%)	$265 (100%)
31295-51	$2,005 x 50% = $1,003	$164 x 50% = $82	$1,932 (100%) – $198 (31231) = $1,734	$163 (100%) – $66 (31231) = $97
TOTAL	**$4,845**	**$348**	**$5,419**	**$362**

EXAMPLE #2

In this example, a patient undergoes a procedure including bilateral frontal sinus balloon dilation, bilateral maxillary sinus balloon dilation, and bilateral sphenoid dilation performed without a FESS procedure.

	2019 PHYSICIAN PAYMENT		2020 PHYSICIAN PAYMENT	
CPT® CODES	**OFFICE**	**FACILITY**	**OFFICE**	**FACILITY**
31298-50	$3,842 x 150% = $5,763	$266 x 150% = $399	$3,685 x 150% = $5,528	$265 x 150% = $397
31295-50-51	$2,005 x 150% = $3,007 x 50% = $1,504	$164 x 150% = $246 x 50% = $123	$1,932 x 150% = 2,898 – $198 (31231) = $2,700	$163 x 150% = $245 – $66 (31231) = $179
TOTAL	**$7,267**	**$522**	**$8,228**	**$576**

EXAMPLE #3

In this example, a patient undergoes a procedure including bilateral frontal balloon dilation, bilateral maxillary FESS, total ethmoidectomy, and sphenoid FESS.

	2019 PHYSICIAN PAYMENT	2020 PHYSICIAN PAYMENT
CPT® CODES	**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	**$1,085**	**$1,294**

FOR ADDITIONAL QUESTIONS OR INFORMATION CONTACT:

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The information 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,Inc. concerning levels of reimbursement, payment or charge. Similarly, all CPT® & HCPCS codes are supplied for information purposes only and represent no statement; promise or guarantee by Acclarent, Inc. that these codes will be appropriate or that reimbursement will be made.

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