EUSTACHIAN TUBE BALLOON DILATION CODING AND PAYMENT
Frequently Asked Questions
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>INDICATIONS FOR USE</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVERAGE</td>
<td>2</td>
</tr>
<tr>
<td>PRIOR AUTHORIZATION / APPROVAL</td>
<td>2</td>
</tr>
<tr>
<td>CODING</td>
<td>3</td>
</tr>
<tr>
<td>MODIFIERS</td>
<td>3</td>
</tr>
<tr>
<td>PAYMENT</td>
<td>4</td>
</tr>
<tr>
<td>APPEALS</td>
<td>4</td>
</tr>
</tbody>
</table>

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 payor. We strongly suggest that you consult your payor 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.

Please contact the Acclarent Reimbursement Hotline at 877.340.6466 if you need assistance.
INDICATIONS FOR USE

Q. What are the indications for use for the Acclarent AERATM Eustachian Tube Balloon Dilation System?

A. The ACCLARENT AERA™ Eustachian Tube Balloon Dilation System is intended to dilate the Eustachian tube for treatment of persistent Eustachian tube dysfunction in adults ages 22 and older.

COVERAGE

Q. Do payors cover Eustachian tube balloon dilation (ETBD) procedures?

A. **Commercial Payors:** 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 reasonable and necessary. 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. Please refer to your individual MACs coverage policies for more information.

PRIOR APPROVAL / AUTHORIZATION

Q. Do payors 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 payor 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 website at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](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 payor could not determine the medical necessity and appropriateness of the proposed treatment, or the services are deemed experimental/investigational. Most payors will have their own appeals process and guidelines and will vary in their timelines and number of appeals that may be requested.

Please contact the Acclarent Reimbursement Hotline at 877.340.6466 if you need assistance.
CODING

Q. What code is used 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. The following code exists within the ENT section of the AMA® 2016 CPT® Professional Codebook:

69799 - unlisted procedure of the middle ear

Q. When will a Category I CPT® code be implemented for this procedure?
A. Prior to the implementation of a Category I CPT® code, the American Medical Association has requirements that must be satisfied. The earliest a Category I code might be available for utilization is January 2019.

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 with other procedures. Report the appropriate CPT® code(s) for other procedures performed during the same operative session as ETBD.

MODIFIERS

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Bilateral Procedure: When bilateral procedures are performed in the same session, append the additional procedure. 50% payment reduction of the second procedure generally applies.</td>
</tr>
<tr>
<td>51</td>
<td>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 payors.</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued Procedure: Under certain circumstances, the physician may elect to terminate the procedure.</td>
</tr>
<tr>
<td>73</td>
<td>Discontinued Outpatient Hospital/Ambulatory Surgery (ASC) Procedure PRIOR TO the Administration of Anesthesia – Applied when extenuating circumstances require the cancellation of a procedure.</td>
</tr>
<tr>
<td>74</td>
<td>Discontinued Outpatient Hospital/Ambulatory Surgery (ASC) Procedure AFTER Administration of Anesthesia – Applies when extenuating circumstances require the cancellation of a procedure.</td>
</tr>
</tbody>
</table>

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. Do I need to use a modifier to note bilateral procedures?
A. Most payors require the use of modifier 50 for bilateral procedures. Consult directly with the payor for specific guidelines.

Please contact the Acclarent Reimbursement Hotline at 877.340.6466 if you need assistance.
Q. The physician was unable to complete the ETBD 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.

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

PAYMENT

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 payor. 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 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 payors have their own guidelines for reviewing/adjudicating claims with unlisted codes. Check with your payor to inquire about individual requirements.

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, or a service for approval:

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

Please contact the Acclarent Reimbursement Hotline at 877.340.6466 if you need assistance.
CODING RESOURCES AND REFERENCES

The following are some of the coding resources available to assist in accurately reporting ETBD services, procedures, and devices.

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

For additional information please contact the Acclarent Reimbursement Hotline:
877.340.6466 or email us at acclarent.reimbursement@milestonecro.com

**OTHER RESOURCES:**

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

American Medical Association: 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 2016 Standard, Complete Official Codebook. AMA ©2015 (www.nchs.cdc.gov) and is available from multiple publishers
- ICD-10-PCS 2016 Standard, Complete Official Codebook. AMA ©2015 (www.cms.gov) and is available from multiple publishers

Medicare Program website: www.cms.gov
- Provides a wide range of information and resources

**FOR ADDITIONAL QUESTIONS OR INFORMATION CONTACT:**
Acclarent.reimbursement@milestonecro.com
877.340.6466
Caution: Federal (U.S.) law restricts the sale, distribution or use of the ACCLARENT AERA™ by or on the order of a physician who is trained in the use of Acclarent technology. Eustachian tube balloon dilation has associated risks, including tissue and mucosal trauma, infection, or possible carotid artery injury. Prior to use, it is important to read the Instructions for Use and to understand the contraindications, warnings, and precautions associated with these devices.

For Physicians: ACCLARENT AERA™ is intended for use by physicians who are trained on Acclarent technology. Eustachian tube balloon dilation has associated risks, including tissue and mucosal trauma, infection, or possible carotid artery injury. Prior to use, it is important to read the Instructions for Use and to understand the contraindications, warnings, and precautions associated with these devices.