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.
PATIENT SELECTION CRITERIA

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

Humana members may be eligible under the Plan for balloon sinus ostial dilation when ALL of the following indications are met:

- Documentation of persistent rhinosinusitis for greater than three months; AND
- Documented failure of medical therapy greater than three months in duration demonstrated by persistent upper respiratory symptoms despite therapy consisting of a minimum of two different antibiotics with a trial of steroid spray, antihistamine spray and/or decongestant; AND
- Radiological evidence of at least ONE of the following:
  - Air fluid levels;
  - Mucosal thickening > 2mm; OR
  - Opacification; OR

COVERAGE

Balloon Sinuplasty is often covered by Public and Commercial Payors. Coverage policies may differ for “stand-alone” and “hybrid” procedures. Check the Acclarent website for further details on coverage in your state at https://www.acclarent.com/tools-and-resources (log in credentials required to view State Coverage Tool).

MEDICARE

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 are built into the Medicare Physician Fee Schedule (MPFS) found at: http://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx.

COMMERCIAL

Q. What steps should I take before performing in-office Balloon Sinuplasty on a Cigna patient? Or, I’ve received payment from Cigna for an in-office procedure but they reimbursed at the facility rate. What should I do now?

A. The following is a summary of the situation pertaining to Cigna and our recommendations.

1. There is no medical policy which limits coverage of sinus balloon dilation procedures in the physician office setting for medically-appropriate patients. As always, providers must confirm benefit eligibility and individual plan exclusions prior to services.

2. The payment issue is due to Cigna’s system not recognizing the Place of Service (POS) where the procedure was performed. Cigna’s system only allows one fee per CPT® code and their system defaults to the facility payment rate (Place of Service 22 or 24).

3. BEFORE treating any Cigna patient, providers must:
   a. Call Cigna to verify their fee schedule for the balloon codes when performed in POS11 (physician office).
   b. If the fee is not correct (i.e. it’s still set at the facility rate), the provider must work with Cigna to correct their fee schedule prior to performing the procedure. Providers must contact their representative on the Contracting Team, the Regional Director of Contracts for their area or the Market Lead for their area and request the following:
      i. Can they change to a new fee schedule, which includes non-facility payment rates for in-office procedures?
      ii. Or, can they amend their provider fee schedule to change from the facility rates to the non-facility rates for CPT® codes 31295, 31296, and 31297 so their patients can have this procedure in the physician office rather than in the hospital or ASC setting.
   c. Cigna may request contract amendment requests be emailed.
PRIOR APPROVAL / AUTHORIZATION

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. Contact the health plan directly for filing instructions and address.
• For Self-insured plans: Be sure your patient has consulted with the employer prior to proceeding to the external review.

Contact the Reimbursement Hotline or log into Acclarent.com 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

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>TYPE</th>
<th>PLACE OF SERVICE (POS) CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>Inpatient Hospital</td>
<td>21</td>
</tr>
<tr>
<td>Facility</td>
<td>Outpatient Hospital</td>
<td>22</td>
</tr>
<tr>
<td>Facility</td>
<td>Ambulatory Surgery Center</td>
<td>24</td>
</tr>
<tr>
<td>Non-Facility</td>
<td>Physician Office</td>
<td>11</td>
</tr>
</tbody>
</table>
NASAL / SINUS ENDOSCOPIC SURGERY CODES

<table>
<thead>
<tr>
<th>SINUS</th>
<th>CPT® CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maxillary</td>
<td>31256</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy;</td>
</tr>
<tr>
<td></td>
<td>31267</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus</td>
</tr>
<tr>
<td>Frontal</td>
<td>31276</td>
<td>Nasal/sinus endoscopy, surgical with frontal sinus exploration; with or without removal of tissue from frontal sinus</td>
</tr>
<tr>
<td>Sphenoid</td>
<td>31287</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy</td>
</tr>
<tr>
<td></td>
<td>31288</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus</td>
</tr>
</tbody>
</table>

**BALLOON SINUPLASTY**

<table>
<thead>
<tr>
<th>SINUS</th>
<th>CPT® CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maxillary</td>
<td>31295</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa</td>
</tr>
<tr>
<td>Frontal</td>
<td>31296</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)</td>
</tr>
<tr>
<td>Sphenoid</td>
<td>31297</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)</td>
</tr>
</tbody>
</table>

Additional information regarding the nasal / sinus endoscopic surgery codes:

- Balloon-only CPT® codes may be used in conjunction with traditional FESS CPT® codes for separate sinuses in a common procedure.
- Balloon-only CPT® codes may not be used 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).

**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 diagnoses codes?

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

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>J32.0</td>
<td>Chronic Maxillary Sinusitis</td>
</tr>
<tr>
<td>J32.1</td>
<td>Chronic Frontal Sinusitis</td>
</tr>
<tr>
<td>J32.2</td>
<td>Chronic Ethmoidal Sinusitis</td>
</tr>
<tr>
<td>J32.3</td>
<td>Chronic Sphenoidal Sinusitis</td>
</tr>
<tr>
<td>J32.4</td>
<td>Chronic pansinusitis</td>
</tr>
<tr>
<td>J32.8</td>
<td>Other chronic sinusitis</td>
</tr>
<tr>
<td>J32.9</td>
<td>Chronic sinusitis, unspecified</td>
</tr>
</tbody>
</table>
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. Payment is typically reduced by 50% for the 2nd and subsequent procedures. Commercial payment rules vary.

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

A. Yes, all sinus surgery codes are unilateral. Most payors 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.

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. Medicare will deny claims for bilateral procedures when submitted with the RT/LT modifiers. 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:

31296-50
31295-50-51
31297-50-51

Commercial plans do not necessarily follow Medicare’s guidelines. It is important to check with each payor 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. 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 payors frequently request supporting documentation when reviewing a claim with Modifier 53.
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

<table>
<thead>
<tr>
<th>CPT® CODE</th>
<th>DESCRIPTR</th>
<th>CPT® CODE</th>
<th>DESCRIPTR</th>
</tr>
</thead>
<tbody>
<tr>
<td>31000</td>
<td>Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)</td>
<td>31256</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31267</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31295</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa</td>
</tr>
<tr>
<td>31002</td>
<td>Lavage by cannulation; sphenoid sinus</td>
<td>31287</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31288</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31297</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)</td>
</tr>
</tbody>
</table>

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).
There are many key terms and acronyms used in medical reimbursement literature. There can be varying definitions of terms per insurance contract. Note: This list contains some key terms and is not meant to be all-inclusive.

**Actual Charge:** The charge actually submitted by a physician or hospital for a service rendered.

**Allowable / Approved Amount:** An insurer-determined amount for a service per CPT® code. Medicare’s payment methodology often can be part of this determination. See Medicare Fee Schedule (MFS).

**APC:** Ambulatory Payment Classification is the Medicare reimbursement methodology under the Hospital Outpatient Prospective Payment System (HOPPS). Similar to MS-DRGs, procedures which require similar resources are assigned to an APC category for a lump sum payment. However, multiple outpatient APCs may potentially be paid to a facility on a single case. CMS publishes national average payment amounts for each APC annually in the Medicare Hospital Outpatient Prospective Payment System Final Rule, Addendums A and B. These national base rates are then adjusted geographically according to the hospital wage index for the area.

**Appeal / Review:** Mechanism for contact with a payor for denied claims when there appears to be a possible oversight in determining benefits.

**Audit:** The act of comparing a physician’s or facility’s medical documentation against the billing records and claims submitted to verify accuracy and appropriateness. Audits may be conducted by a variety of payors, or internally by the entity as part of compliance activities. Note: Prepayment or prospective audit appears to be a growing trend among payors, including Medicare.

- **Prospective Review (Prepayment Audit):** Where documentation is requested for review prior to reimbursing a claim. Many facilities and practices conduct internal audit as a preventive tool to improve accuracy and reduce the possibility of unintended overpayment. With a goal of efficiency overall and accuracy in the initial payment of claims, Medicare now engages private entities regionally to serve as recovery audit contractors (RACs), in addition to its internal audit staff. Commercial plans may also outsource review functions to third parties.

- **Retrospective Review (Postpayment Audit):** This original method of payor audit reviews paid claims. This is the method most likely performed by a payor investigating the possibility of overpayments. Audit can result in overpayments to be refunded, and also in potential fines, penalties and sanctions such as loss of provider status in government-based insurance programs. Commercial payors may also conduct some form of audit.

**BSP:** Balloon Sinuplasty is a safe and effective endoscopic sinus procedure for chronic sinusitis patients seeking relief from uncomfortable sinus pain symptoms.

**CCI:** National Correct Coding Initiative (NCCI). These are claims processing edits implemented by the Medicare program and also sometimes used by commercial plans. There are two types: Comprehensive/component, or Column 1/Column 2 edits, indicate bundling – the procedure in column 2 is a component of the more comprehensive procedure in column 1, and not typically reimbursed separately. Mutually Exclusive edits indicate that either service may be reported, but usually not both together, as the procedure descriptors are contradictory (eg, “with” vs. “without”; “unilateral” vs. “bilateral”; or “limited” vs. “complete”). CCI edits apply to physician claims, and are also incorporated into the Outpatient Code Editor (OCE) for outpatient facility services.

**CMS:** Centers for Medicare and Medicaid Services, part of the Federal Department of Health and Human Services (HHS), division overseeing these programs.

**Coding:** A “language” of numeric and alpha-numeric code sets intended to translate medical conditions and medical services for electronic submission of claims data by physicians and facilities on behalf of the insured individual.

**Coding and Billing Compliance Guidance:** Published by the HHS Office of Inspector General (OIG) to encourage coding and billing accuracy in claims submitted on behalf of Medicare and Medicaid beneficiaries. While adoption of a ‘corporate compliance program’ is stated as voluntary, most facilities and physicians implement at least some of the program elements. To verify compliant billing and coding, a facility or physician can be identified for review (audit).

**Cost Sharing:** Common payor methodology in which the insured individual must pay out-of-pocket a portion of the costs associated with receiving care, e.g., copayment, coinsurance and deductible.

**Covered Service / Medical Necessity:** A service or supply that is part of the benefit plan and eligible for reimbursement. Criteria are set forth by payors per CPT® code to determine parameters of coverage. Frequently, these involve medical conditions identified with ICD-10 diagnosis codes.
CPT®: Current Procedural Terminology (CPT®) is the primary codebook for reporting physician or outpatient facility services. Published annually by the American Medical Association, it is structured to report physician services.

Edits: Payors’ prepayment “screens” used to identify potential conflicts affecting coverage, e.g., CCI.

FESS: Functional endoscopic sinus surgery is a surgical treatment of sinusitis and nasal polyps, including bacterial, fungal, recurrent acute, and chronic sinus problems. FESS uses nasal endoscopes and other tools to restore drainage of the paranasal sinuses and ventilation of the nasal cavity.

HCPCS: Healthcare Common Procedural Coding System. The HCPCS system includes the CPT® as Level I codes, and also the Level II National Codes – which are commonly referred to as “HCPCS codes.” CMS maintains Level II codes, to report a diverse range of services and items not included in CPT® – supplies, devices, injectable drugs, ambulance transport, DME, etc. Level II National codes are often more limited in use, applying only to a specific payor or provider type; for example, C-codes for devices may only be reported with outpatient hospital or ASC claims. Not every supply or device will have a specific assigned HCPCS code, and multiple products may fall into a single code descriptor.

ICD-10-CM: International Classification of Diseases, 10th Revision. ICD-10-CM replaced ICD-9-CM, Volumes 1 and 2 on October 1, 2015; Specific revisions in ICD-10 include: the addition of information relevant to ambulatory and managed care encounters; expanded injury codes; the creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition; the addition of sixth and seventh characters; incorporation of common 4th and 5th digit sub-classifications; laterality; and greater specificity in code assignment. The new structure allows further expansion than was possible with ICD-9-CM.

ICD-10-PCS: The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) replaces Volume 3 of ICD-9-CM on October 1, 2015. Unlike ICD-9-CM procedure codes, ICD-10-PCS does not mirror the structure of the diagnosis coding system, but was designed specifically to meet the needs of procedure coding. ICD-10-PCS is based on a seven character multi-axial code structure, where each character represents a specific aspect of a procedure, the meaning of which may vary from one section to another; a code is derived by choosing a specific value for each of the seven characters. Because the definition of each character is a function of its physical position in the code, the same value (number or letter) placed in different position in the code means something different. An ICD-10-PCS code is best understood as a process rather than an isolated fixed quantity. The ability to revise valid values for an axis of classification as needed allows ICD-10-PCS to be complete, expandable, and have a high degree of flexibility.

Place of Service (POS): CMS has designated a series of two-digit indicators for the place of service. The place of service may affect reimbursement of certain procedures.

Prior Authorization: Permission may be required by insurers prior to scheduling or paying for particular medical services recommended by providers. May be referred to as precertification or prior approval.

RBRVS: Resource-Based Relative Value Scale. The methodology by which the Medicare physician fee schedule is calculated. RBRVS has been in use since 1992. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS). In the RBRVS system, payments for services are determined by the resource costs needed to provide them.

RVU: Relative value unit. The numeric relative weights assigned to each CPT® code in RBRVS. Each procedure code is assigned a relative weight based upon resources needed to provide it, which has three components: physician work, practice expense, and malpractice liability. Although CMS indicates an average percentage of the total RVU for each of these components (physician work 52%, practice expense 44%, malpractice liability 4%), this is not a fixed ratio, and will vary according to the specific resources relevant for different types of procedures. Each of these component relative weights may be adjusted geographically, and then the sum is multiplied by a dollar-per-unit conversion factor to arrive at the final allowed amount.
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 Hotline:

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

**OTHER RESOURCES:**


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