2018 ACCLARENT REIMBURSEMENT GUIDE

Physician and Facility

Acclarent®

PART OF THE Johnson & Johnson FAMILY OF COMPANIES

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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.

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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.

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 2018 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	$2,199	J1	$952	A2
30420	Rhinoplasty, primary; including major septal repair	5165	$4,338	J1	$2,143	A2
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	5164	$2,199	J1	$952	A2
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial	5163	$1,138	T	$593	A2
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	5161	$178	T	$93	P2
31002	Lavage by cannulation; sphenoid sinus	5163	$1,138	T	$593	R2
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	5151	$157	T	$82	P2
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	5153	$1,324	J1	$588	A2
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	5153	$1,324	J1	$588	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	$4,864	J1	$1,768	G2
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	5155	$4,864	J1	$1,768	A2
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	5155	$4,864	J1	$1,768	A2
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy	5154	$2,616	J1	$1,148	A2
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	5155	$4,864	J1	$1,768	G2
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	5155	$4,864	J1	$1,768	G2
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	5155	$4,864	J1	$1,768	A2
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	5155	$4,864	J1	$1,768	A2
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy	5155	$4,864	J1	$1,768	A2
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	5155	$4,864	J1	$1,768	A2

31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	5155	$4,864	J1	$1,768	P2
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g. balloon dilation)	5155	$4,864	J1	$1,768	P2
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g. balloon dilation)	5155	$4,864	J1	$1,768	P2
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	5155	$4,864	J1	$1,768	G2
42830	Adenoidectomy, primary; younger than age 12	5164	$2,199	J1	$952	A2
42831	Adenoidectomy, primary; age 12 or older	5164	$2,199	J1	$952	A2
42835	Adenoidectomy, secondary; younger than age 12	5164	$2,199	J1	$952	A2
42836	Adenoidectomy, secondary; age 12 or over	5164	$2,199	J1	$952	A2

OUTPATIENT FACILITY 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.

<table>
<tr><th>BALLOON-ONLY PROCEDURE</th><th>HYBRID PROCEDURE</th><th colspan="2">HOSPITAL OUTPATIENT
(POS 22)
2018 MEDICARE PAYMENT</th></tr>
<tr><th>CPT® CODES</th><th>CPT® CODES</th><th>BALLOON ONLY</th><th>HYBRID</th></tr>
<tr><td>31296-50 (APC 5155)
Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g. balloon dilation)</td><td>31276-50 (APC 5155)
Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus</td><td rowspan="2">APC 5155 (Level 5 Airway Endoscopy)</td><td rowspan="2">APC 5155 (Level 5 Airway Endoscopy)</td></tr>
<tr><td>31295-50-51 (APC 5155)
Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa</td><td>31267–50-51 (APC 5155)
Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus</td></tr>
<tr><td colspan="2">Total Estimated Medicare Payment:</td><td>$4,864</td><td>$4,864</td></tr>
</table>

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.

<table>
<tr><th>BALLOON-ONLY PROCEDURE</th><th>HYBRID PROCEDURE</th><th colspan="2">AMBULATORY SURGERY CENTER
(POS 24)
2018 MEDICARE PAYMENT</th></tr>
<tr><th>CPT® CODES</th><th>CPT® CODES</th><th>BALLOON ONLY</th><th>HYBRID</th></tr>
<tr><td rowspan="2">31296-50
Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g. balloon dilation)</td><td rowspan="2">31276-50
Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus</td><td>$2,652</td><td>$2,652</td></tr>
<tr><td colspan="2">(Payment x Bilateral adjustment)</td></tr>
<tr><td rowspan="2">31295-50-51
Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa</td><td rowspan="2">31267–50-51
Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus</td><td>$1,326</td><td>$1,326</td></tr>
<tr><td colspan="2">(Payment x Bilateral adjustment x Multiple Procedure Reduction)</td></tr>
<tr><td colspan="2">Total Estimated Medicare Payment:</td><td>$3,978</td><td>$3,978</td></tr>
</table>

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 2018 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**
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	5164	$2,199	J1	$952	A2
69424	Ventilating tube removal requiring general anesthesia	5164	$2,199	Q2	$95	P3
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	5163	$1,138	T	$593	A2
69501	Transmastoid antrotomy (simple mastoidectomy)	5165	$4,338	J1	$2,143	A2
69502	Mastoidectomy; complete	5165	$4,338	J1	$2,143	A2
69540	Excision aural polyp (resection of cholesteatoma of the middle ear)	5163	$1,138	T	$160	P3
69610	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch	5164	$2,199	J1	$206	P3
69620	Myringoplasty (surgery confined to drumhead and donor area)	5164	$2,199	J1	$953	A2
69631	Tympanoplasty without mastoidectomy, initial or revision; without ossicular chain reconstruction	5165	$4,338	J1	$2,143	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	$4,338	J1	$2,143	A2
69635	Tympanoplasty with antrotomy or mastoidotomy; without ossicular chain reconstruction	5165	$4,338	J1	$2,143	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	$4,338	J1	$2,143	A2
69641	Tympanoplasty with mastoidectomy; without ossicular chain reconstruction	5165	$4,338	J1	$2,143	A2
69642	Tympanoplasty with mastoidectomy; with ossicular chain reconstruction	5165	$4,338	J1	$2,143	A2
69643	Tympanoplasty with mastoidectomy; with intact or reconstructed wall, without ossicular chain reconstruction	5165	$4,338	J1	$2,143	A2
69644	Tympanoplasty with mastoidectomy; with intact or reconstructed wall, with ossicular chain reconstruction	5165	$4,338	J1	$2,143	A2
69799	Unlisted procedure, middle ear	5161	$178	T	N/A Excluded from coverage and payment in an ASC	N/A

CY 2018 FINAL HOSPITAL OUTPATIENT AND AMBULATORY SURGICAL CENTER PAYMENT (HCPCS CODE)

		HOSPITAL OUTPATIENT (POS 22)			AMBULATORY SURGERY CENTER (POS 24)	
HCPCS CODE	**DESCRIPTION**	**APC**	**MEDICARE NATIONAL AVERAGE PAYMENT**	**SI**	**MEDICARE NATIONAL AVERAGE PAYMENT**	**PI**
C9745*	Nasal endoscopy, surgical; balloon dilation of eustachian tube	5165	$4,338	J1	$2,950	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 2018 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	$1,324	J1	$588	A2
31527	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator	5154	$2,616	J1	$1,148	A2
31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial	5154	$2,616	J1	$1,148	A2
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	5154	$2,616	J1	$1,148	A2
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope	5154	$2,616	J1	$1,148	A2
31615	Tracheobronchoscopy through established tracheostomy incision	5162	$460	T	$240	A2
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	5154	$2,616	J1	$1,148	A2
31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	5155	$4,864	J1	$1,768	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	$2,616	J1	$1,148	A2

COMPUTER ASSISTED SURGICAL NAVIGATION

CY 2018 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 2018 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	5.12	7.81	$184	$281
30420	Rhinoplasty, primary; including major septal repair	90	38.41	N/A	$1,383	N/A
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	90	17.43	N/A	$627	N/A
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial	10	3.83	6.41	$138	$231
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	10	2.99	5.21	$108	$187
31002	Lavage by cannulation; sphenoid sinus	10	5.29	N/A	$190	N/A
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	0	1.85	5.96	$67	$215
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	0	4.56	7.43	$164	$267
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	0	4.54	N/A	$163	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	14.38	N/A	$518	N/A
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	0	6.99	11.54	$252	$415
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	0	9.29	N/A	$334	N/A
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy	0	5.17	N/A	$186	N/A
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	0	12.80	N/A	$461	N/A
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	$489	N/A
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	0	7.62	N/A	$274	N/A
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	0	10.85	N/A	$391	N/A
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy	0	5.78	N/A	$208	N/A

31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	0	6.72	N/A	$242	N/A
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	0	4.52	57.07	$163	$2,055
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g. balloon dilation)	0	5.16	57.80	$186	$2,081
31297	Nasal/sinus endoscopy, surgical; with dilation of sphe-noid sinus ostium (e.g. balloon dilation)	0	4.11	56.67	$148	$2,040
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	0	7.33	109.84	$264	$3,954
42830	Adenoidectomy, primary; younger than age 12	90	5.89	N/A	$212	N/A
42831	Adenoidectomy, primary; age 12 or older	90	6.36	N/A	$229	N/A
42831	Adenoidectomy, secondary; younger than age 12	90	5.47	N/A	$197	N/A
42836	Adenoidectomy, secondary; age 12 or over	90	6.85	N/A	$247	N/A

PHYSICIAN PROFESSIONAL PAYMENT EXAMPLE

The following case example is based upon the 2018 Medicare Physician Fee Schedule. In this example, a patient undergoes a procedure including bilateral maxillary sinus balloon dilation and bilateral 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 ESS surgery and when tissue is removed, the traditional ESS codes should be used (see: http://www.entnet.org/Practice/Balloon-Dilation.cfm).

CPT® CODES	2018 MEDICARE NON-FACILITY PAYMENT (PHYSICIAN OFFICE - POS 11)*	2018 MEDICARE FACILITY PAYMENT (ASC - POS 24 OR HOSPITAL - POS 22)
31296-50 Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g. balloon dilation)	$2,081 x 150% = $3,122	$186 x 150% = $279
31295-50-51 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation)	($2,055 x 150%) x 50% = $1,541	($163 x 150%) x 50% = $122
Total Estimated Medicare Payment:	**$4,663**	**$401**

*Non-facility payment includes the cost of disposables.

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 2018 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
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	10	4.20	N/A	$151	N/A
69424	Ventilating tube removal requiring general anesthesia	0	1.75	3.60	$63	$130
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	10	4.52	N/A	$164	N/A
69501	Transmastoid antrotomy (simple mastoidectomy)	90	20.66	N/A	$744	N/A
69502	Mastoidectomy; complete	90	27.45	N/A	$988	N/A
69540	Excision aural polyp (resection of cholesteatoma of the middle ear)	10	3.59	5.86	$129	$211
69610	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch	10	8.24	10.83	$297	$390
69620	Myringoplasty (surgery confined to drumhead and donor area)	90	13.79	19.47	$496	$701
69631	Tympanoplasty without mastoidectomy, initial or revision; without ossicular chain reconstruction	90	24.94	N/A	$898	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	29.48	N/A	$1,061	N/A
69635	Tympanoplasty with antrotomy or mastoidotomy; without ossicular chain reconstruction	90	34.94	N/A	$1,258	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	39.29	N/A	$1,414	N/A
69641	Tympanoplasty with mastoidectomy; without ossicular chain reconstruction	90	29.38	N/A	$1,058	N/A
69642	Tympanoplasty with mastoidectomy; with ossicular chain reconstruction	90	37.71	N/A	$1,358	N/A
69643	Tympanoplasty with mastoidectomy; with intact or reconstructed wall, without ossicular chain reconstruction	90	34.54	N/A	$1,243	N/A
69644	Tympanoplasty with mastoidectomy; with intact or reconstructed wall, with ossicular chain reconstruction	90	41.71	N/A	$1,502	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 2018 FINAL PHYSICIAN PAYMENT

			RELATIVE VALUE UNITS (RVUs)		MEDICARE NATIONAL AVERAGE PAYMENT	
CPT® CODE	DESCRIPTION	GLOBAL DAYS	FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
31526	Laryngoscopy direct, with or without tracheoscopy; diagnostic, with operating microscope or telescope	0	4.47	N/A	$161	N/A
31527	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator	0	5.57	N/A	$201	N/A
31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial	0	4.11	N/A	$148	N/A
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	0	4.60	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	N/A	$118	N/A
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	0	5.75	N/A	$207	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	6.59	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	7.42	N/A	$267	N/A

COMPUTER ASSISTED SURGICAL NAVIGATION

CY 2018 FINAL PHYSICIAN PAYMENT

			RELATIVE VALUE UNITS (RVUs)		MEDICARE NATIONAL AVERAGE PAYMENT	
CPT® CODE	DESCRIPTION	GLOBAL DAYS	FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
+61782*	Stereotactic computer-assisted (navigational) procedure; cranial, extradural	ZZZ**	5.01	N/A	$180	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.
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. 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® products are not used in all procedures listed. The most appropriate code for the patient's clinical presentation must be selected.
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Sources: Calendar Year 2018 Medicare Outpatient Prospective Payment System, Final Rule [CMS-1678-FC], Federal Register, November 13, 2017 and its associated addenda posted on the Centers for Medicare and Medicaid Services web site on November 1, 2017. 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 2018 Medicare Physician Fee Schedule, Final Rule [CMS-1676-F]. Federal Register, November 15, 2017. No geographic adjustments have been made to the reported payment rates.

STATUS INDICATOR (SI) DEFINITIONS: 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 ASC list in CY 2008 or later; paid at adjusted rate; **J8** - Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate. **N1**- Packaged service/item; no separate payment made. **P2** - Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight. **P3** - Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on based on MPFS non- facility PE RVUs.

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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