2019 ACCLARENT REIMBURSEMENT GUIDE

Physician and Facility

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This guide has been developed to assist you in obtaining physician and facility reimbursement for:

- Nasal/Sinus Endoscopic Surgery
- Neuroendoscopy
- Computer Assisted Surgical Navigation
- Eustachian Tube Balloon Dilation
- Airway Endoscopic Surgery

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.

FACILITY

PHYSICIAN

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 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 that these codes will be appropriate or that reimbursement will be made.The third-party trademarks used herein are trademarks of their respective owners.

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 2019 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
30130	Excision inferior turbinate, partial or complete, any method	5164	$2,231	J1	$968	A2
30140	Submucous resection, inferior turbinate, partial or complete, any method	5164	$2,231	J1	$968	A2
30420	Rhinoplasty, primary; including major septal repair	5165	$4,424	J1	$2,175	A2
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	5164	$2,231	J1	$968	A2
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial	5163	$1,279	T	$564	A2
30930	Fracture nasal inferior turbinate(s), therapeutic	5164	$2,231	J1	$968	A2
30999	Unlisted procedure, nose	5161	$206	T	N/A Excluded from coverage and payment in an ASC	N/A
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	5161	$206	T	$106	P2
31002	Lavage by cannulation; sphenoid sinus	5163	$1,279	J1	$564	R2
31020	Sinusotomy, maxillary (antrotomy); intranasal	5164	$2,231	J1	$968	A2
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	5165	$4,424	J1	$2,175	A2
31032	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps	5165	$4,424	J1	$2,175	A2
31050	Sinusotomy, sphenoid, with or without biopsy;	5165	$4,424	J1	$2,175	A2
31051	Sinusotomy, sphenoid, with or without biopsy; with mucosal stripping or removal of polyp(s)	5165	$4,424	J1	$2,175	A2
31075	Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type)	5165	$4,424	J1	$2,175	A2
31080	Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation)	5165	$4,424	J1	$2,175	A2
31081	Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation)	5165	$4,424	J1	$2,175	A2
31084	Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision	5165	$4,424	J1	$2,175	A2
31085	Sinusotomy frontal; obliterative, with osteoplastic flap, coronal incision	5165	$4,424	J1	$2,175	A2
31090	Sinusotomy, unilateral, 3 or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid)	5165	$4,424	J1	$2,175	A2
31200	Ethmoidectomy; intranasal, anterior	5165	$4,424	J1	$2,175	A2

		HOSPITAL OUTPATIENT (POS 22)			AMBULATORY SURGERY CENTER (POS 24)	
CPT®	DESCRIPTION	APC	MEDICARE NATIONAL AVERAGE PAYMENT	SI	MEDICARE NATIONAL AVERAGE PAYMENT	PI
31201	Ethmoidectomy; intranasal, total	5164	$2,231	J1	$968	A2
31205	Ethmoidectomy; extranasal, total	5164	$2,231	J1	$968	A2
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	5153	$1,369	J1	$604	A2
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	5154	$2,741	J1	$1,180	A2
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	5153	$1,369	J1	$604	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	$5,148	J1	$1,791	G2
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	5155	$5,148	J1	$1,791	A2
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	5155	$5,148	J1	$1,791	A2
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy	5154	$2,741	J1	$1,180	A2
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	5155	$5,148	J1	$1,791	G2
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	5155	$5,148	J1	$1,791	G2
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	5155	$5,148	J1	$1,791	A2
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	5155	$5,148	J1	$1,791	A2
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy	5155	$5,148	J1	$1,791	A2
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	5155	$5,148	J1	$1,791	A2
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	5155	$5,148	J1	$1,791	P2
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g. balloon dilation)	5155	$5,148	J1	$1,791	P2
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g. balloon dilation)	5155	$5,148	J1	$1,791	P2
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	5155	$5,148	J1	$1,791	G2
42821	Tonsillectomy and adenoidectomy; age 12 or over	5164	$2,231	J1	$968	A2
42825	Tonsillectomy, primary or secondary; younger than age 12	5165	$4,424	J1	$2,175	A2
42826	Tonsillectomy, primary or secondary; age 12 or over	5164	$2,231	J1	$968	A2
42830	Adenoidectomy, primary; younger than age 12	5164	$2,231	J1	$968	A2
42831	Adenoidectomy, primary; age 12 or older	5164	$2,231	J1	$968	A2
42835	Adenoidectomy, secondary; younger than age 12	5164	$2,231	J1	$968	A2
42836	Adenoidectomy, secondary; age 12 or over	5164	$2,231	J1	$968	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.

BALLOON-ONLY PROCEDURE	HYBRID PROCEDURE	HOSPITAL OUTPATIENT (POS 22) 2019 MEDICARE PAYMENT	
CPT® CODES	**CPT® CODES**	**BALLOON ONLY**	**HYBRID**
31296-50 (APC 5155) Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g. balloon dilation)	**31276-50 (APC 5155)** Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	APC 5155 (Level 5 Airway Endoscopy)	APC 5155 (Level 5 Airway Endoscopy)
31295-50-51 (APC 5155) Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	**31267–50-51 (APC 5155)** Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus		
Total Estimated Medicare Payment:		**$5,148**	**$5,148**

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.

BALLOON-ONLY PROCEDURE	HYBRID PROCEDURE	AMBULATORY SURGERY CENTER (POS 24) 2019 MEDICARE PAYMENT	
CPT® CODES	**CPT® CODES**	**BALLOON ONLY**	**HYBRID**
31296-50 Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g. balloon dilation)	**31276-50** Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	$2,687	$2,687
		(Payment x Bilateral adjustment)	
31295-50-51 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	**31267–50-51** Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	$1,343	$1,343
		(Payment x Bilateral adjustment x Multiple Procedure Reduction)	
Total Estimated Medicare Payment:		**$4,030**	**$4,030**

NEUROENDOSCOPY

CY 2019 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
62165	Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach	Not Reimbursed by CMS in Outpatient or ASC				
64999	Unlisted procedure, nervous system	5441	$247	T	N/A Excluded from coverage and payment in an ASC	N/A

COMPUTER ASSISTED SURGICAL NAVIGATION

CY 2019 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

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 2019 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	$2,231	J1	$968	A2
69424	Ventilating tube removal requiring general anesthesia	5164	$2,231	Q2	$96	P3
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	5163	$1,279	J1	$564	A2
69501	Transmastoid antrotomy (simple mastoidectomy)	5165	$4,424	J1	$2,175	A2
69502	Mastoidectomy; complete	5165	$4,424	J1	$2,175	A2
69505	Mastoidectomy; modified radical	5165	$4,424	J1	$2,175	A2
69511	Mastoidectomy; radical	5165	$4,424	J1	$2,175	A2
69540	Excision aural polyp (resection of cholesteatoma of the middle ear)	5163	$1,279	J1	$160	P3
69610	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch	5164	$2,231	J1	$206	P3
69620	Myringoplasty (surgery confined to drumhead and donor area)	5164	$2,231	J1	$968	A2
69631	Tympanoplasty without mastoidectomy, initial or revision; without ossicular chain reconstruction	5165	$4,424	J1	$2,175	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	$4,424	J1	$2,175	A2
69635	Tympanoplasty with antrotomy or mastoidotomy; without ossicular chain reconstruction	5165	$4,424	J1	$2,175	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	$4,424	J1	$2,175	A2
69641	Tympanoplasty with mastoidectomy; without ossicular chain reconstruction	5165	$4,424	J1	$2,175	A2
69642	Tympanoplasty with mastoidectomy; with ossicular chain reconstruction	5165	$4,424	J1	$2,175	A2
69643	Tympanoplasty with mastoidectomy; with intact or reconstructed wall, without ossicular chain reconstruction	5165	$4,424	J1	$2,175	A2
69644	Tympanoplasty with mastoidectomy; with intact or reconstructed wall, with ossicular chain reconstruction	5165	$4,424	J1	$2,175	A2

		HOSPITAL OUTPATIENT (POS 22)			AMBULATORY SURGERY CENTER (POS 24)	
CPT® CODE	DESCRIPTION	APC	MEDICARE NATIONAL AVERAGE PAYMENT	SI	MEDICARE NATIONAL AVERAGE PAYMENT	PI
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	5165	$4,424	J1	$2,175	A2
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	5165	$4,424	J1	$2,175	A2
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;	5165	$4,424	J1	$2,175	A2
69661	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out	5165	$4,424	J1	$2,175	A2
69662	Revision of stapedectomy or stapedotomy	5165	$4,424	J1	$2,175	A2
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	5115	$10,714	J1	$8,646	J8
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	5116	$15,402	J1	$12,224	J8
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/ cochlear stimulator; without mastoidectomy	5114	$5,700	J1	$4,500	J8
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/ cochlear stimulator; with mastoidectomy	5115	$10,714	J1	$5,279	G2
69799	Unlisted procedure, middle ear	5161	$206	T	N/A Excluded from coverage and payment in an ASC	N/A
69930	Cochlear device implantation, with or without mastoidectomy	5166	$31,968	J1	$30,079	J8

CY 2019 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	$4,424	J1	$3,061	J8

*Applicable to Hospital Outpatient and ASC only. Physicians will continue to report the unlisted CPT® code for procedures of the middle ear.

OUTPATIENT FACILITY PAYMENT EXAMPLE

In this example, a patient undergoes a bilateral Eustachian tube balloon dilation procedure.

EUSTACHIAN TUBE BALLOON DILATION PROCEDURE	HOSPITAL OUTPATIENT (POS 22) 2019 MEDICARE PAYMENT
CPT® CODES	**BILATERAL PROCEDURE**
C9745-RT (APC 5165) Nasal endoscopy, surgical; balloon dilation of eustachian tube	**APC 5165 (Level 5 ENT Procedures)**
C9745-LT (APC 5165) Nasal endoscopy, surgical; balloon dilation of eustachian tube	
Total Estimated Medicare Payment:	**$4,424**

AMBULATORY SURGERY CENTER PAYMENT EXAMPLE

In this example, a patient undergoes a bilateral Eustachian tube balloon dilation procedure.

EUSTACHIAN TUBE BALLOON DILATION PROCEDURE	AMBULATORY SURGERY CENTER (POS 24) 2019 MEDICARE PAYMENT
CPT® CODES	**BILATERAL PROCEDURE**
C9745-RT Nasal endoscopy, surgical; balloon dilation of eustachian tube	$3,061
C9745-LT Nasal endoscopy, surgical; balloon dilation of eustachian tube	$1,531 (Payment X Bilateral adjustment)
Total Estimated Medicare Payment:	**$4,592**

AIRWAY ENDOSCOPIC SURGERY

CY 2019 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	$1,369	J1	$604	A2
31527	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator	5154	$2,741	J1	$1,180	A2
31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial	5154	$2,741	J1	$1,180	A2
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	5154	$2,741	J1	$1,180	A2
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope	5154	$2,741	J1	$1,180	A2
31615	Tracheobronchoscopy through established tracheostomy incision	5162	$487	T	$251	A2
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	5154	$2,741	J1	$1,180	A2
31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	5155	$5,148	J1	$1,791	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	$2,741	J1	$1,180	A2

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 2019 FINAL PHYSICIAN PAYMENT

			RELATIVE VALUE UNITS (RVUS)		MEDICARE NATIONAL AVERAGE PAYMENT	
CPT®	DESCRIPTION	GLOBAL	FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
30130	Excision inferior turbinate, partial or complete, any method	90	11.02	N/A	$397	N/A
30140	Submucous resection, inferior turbinate, partial or complete, any method	0	5.12	7.92	$185	$285
30420	Rhinoplasty, primary; including major septal repair	90	39.42	N/A	$1,421	N/A
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	90	18.04	N/A	$650	N/A
30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial	10	3.98	6.32	$143	$228
30930	Fracture nasal inferior turbinate(s), therapeutic	10	3.43	N/A	$124	N/A
30999	Unlisted procedure, nose	3.43	N/A**	N/A**	At the discretion of the payor***	At the discretion of the payor***
31000	Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	10	3.02	5.17	$109	$186
31002	Lavage by cannulation; sphenoid sinus	10	5.39	N/A	$194	N/A
31020	Sinusotomy, maxillary (antrotomy); intranasal	90	10.44	13.69	$376	$493
31030	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) without removal of antrochoanal polyps	90	15.00	19.14	$541	$690
31032	Sinusotomy, maxillary (antrotomy); radical (Caldwell-Luc) with removal of antrochoanal polyps	90	16.52	N/A	$595	N/A
31050	Sinusotomy, sphenoid, with or without biopsy;	90	13.94	N/A	$502	N/A
31051	Sinusotomy, sphenoid, with or without biopsy; with mucosal stripping or removal of polyp(s)	90	18.63	N/A	$671	N/A
31075	Sinusotomy frontal; transorbital, unilateral (for mucocele or osteoma, Lynch type)	90	22.46	N/A	$809	N/A
31080	Sinusotomy frontal; obliterative without osteoplastic flap, brow incision (includes ablation)	90	29.55	N/A	$1,065	N/A
31081	Sinusotomy frontal; obliterative, without osteoplastic flap, coronal incision (includes ablation)	90	31.83	N/A	$1,147	N/A
31084	Sinusotomy frontal; obliterative, with osteoplastic flap, brow incision	90	32.87	N/A	$1,185	N/A
31085	Sinusotomy frontal; obliterative, with osteoplastic flap, coronal incision	90	34.12	N/A	$1,230	N/A
31090	Sinusotomy, unilateral, 3 or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid)	90	29.68	N/A	$1,070	N/A
31200	Ethmoidectomy; intranasal, anterior	90	16.74	N/A	$603	N/A

			RELATIVE VALUE UNITS (RVUS)		MEDICARE NATIONAL AVERAGE PAYMENT	
CPT®	DESCRIPTION	GLOBAL	FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
31201	Ethmoidectomy; intranasal, total	90	21.48	N/A	$774	N/A
31205	Ethmoidectomy; extranasal, total	90	26.11	N/A	$941	N/A
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	0	1.86	5.69	$67	$205
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)	0	4.58	7.26	$165	$262
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy	10	17.57	N/A	$633	N/A
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection	0	4.56	N/A	$164	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	14.44	N/A	$520	N/A
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	0	7.01	11.78	$253	$425
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	0	9.33	N/A	$336	N/A
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy	0	5.19	N/A	$187	N/A
31257	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy	0	12.88	N/A	$464	N/A
31259	Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus	0	13.64	N/A	$492	N/A
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	0	7.65	N/A	$276	N/A
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	0	10.92	N/A	$394	N/A
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy	0	5.80	N/A	$209	N/A
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	0	6.75	N/A	$243	N/A
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	0	4.55	55.63	$164	$2,005
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g. balloon dilation)	0	5.17	56.36	$186	$2,031
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g. balloon dilation)	0	4.14	55.23	$149	$1,990
31298	Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostia (eg, balloon dilation)	0	7.37	106.61	$266	$3,842
42821	Tonsillectomy and adenoidectomy; age 12 or over	90	8.62	N/A	$311	N/A
42825	Tonsillectomy, primary or secondary; younger than age 12	90	7.51	N/A	$271	N/A

			RELATIVE VALUE UNITS (RVUS)		MEDICARE NATIONAL AVERAGE PAYMENT	
CPT®	DESCRIPTION	GLOBAL	FACILITY TOTAL	NON-FACILITY TOTAL	FACILITY PAYMENT	NON-FACILITY PAYMENT
42826	Tonsillectomy, primary or secondary; age 12 or over	90	7.21	N/A	$260	N/A
42830	Adenoidectomy, primary; younger than age 12	90	5.95	N/A	$214	N/A
42831	Adenoidectomy, primary; age 12 or older	90	6.43	N/A	$232	N/A
42836	Adenoidectomy, secondary; age 12 or over	90	6.89	N/A	$248	N/A

* 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

PHYSICIAN PROFESSIONAL PAYMENT EXAMPLE

The following case example is based upon the 2019 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	2019 MEDICARE NON-FACILITY PAYMENT (PHYSICIAN OFFICE - POS 11)*	2019 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)	$2,031 x 150% = $3,047	$186 x 150% = $279
31295-50-51 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation)	($2,005 x 150%) x 50% = $1,504	($164 x 150%) x 50% = $123
Total Estimated Medicare Payment:	**$4,551**	**$402**

*Non-facility payment includes the cost of disposables.

NEUROENDSCOPY

CY 2019 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
62165	Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach	90	44.61	N/A	$1,608	N/A
64999	Unlisted procedure, nervous system	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

COMPUTER ASSISTED SURGICAL NAVIGATION

CY 2019 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**	5.02	N/A	$181	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.

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 2019 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	4.22	N/A	$152	N/A
69424	Ventilating tube removal requiring general anesthesia	0	1.75	3.63	$63	$131
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	10	4.51	N/A	$163	N/A
69501	Transmastoid antrotomy (simple mastoidectomy)	90	20.62	N/A	$743	N/A
69502	Mastoidectomy; complete	90	27.36	N/A	$986	N/A
69505	Mastoidectomy; modified radical	90	34.28	N/A	$1,235	N/A
69511	Mastoidectomy; radical	90	35.13	N/A	$1,266	N/A
69540	Excision aural polyp (resection of cholesteatoma of the middle ear)	10	3.59	5.87	$129	$212
69610	Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch	10	8.27	10.83	$298	$390
69620	Myringoplasty (surgery confined to drumhead and donor area)	90	13.89	19.82	$501	$714
69631	Tympanoplasty without mastoidectomy, initial or revision; without ossicular chain reconstruction	90	25.13	N/A	$906	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	29.71	N/A	$1,071	N/A
69635	Tympanoplasty with antrotomy or mastoidotomy; without ossicular chain reconstruction	90	35.39	N/A	$1,275	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	39.90	N/A	$1,438	N/A
69641	Tympanoplasty with mastoidectomy; without ossicular chain reconstruction	90	29.62	N/A	$1,067	N/A
69642	Tympanoplasty with mastoidectomy; with ossicular chain reconstruction	90	38.08	N/A	$1,372	N/A
69643	Tympanoplasty with mastoidectomy; with intact or reconstructed wall, without ossicular chain reconstruction	90	34.79	N/A	$1,254	N/A
69644	Tympanoplasty with mastoidectomy; with intact or reconstructed wall, with ossicular chain reconstruction	90	42.18	N/A	$1,520	N/A

		RELATIVE VALUE UNITS (RVUs)			MEDICARE NATIONAL AVERAGE PAYMENT	
CPT® CODE	**DESCRIPTION**	**GLOBAL**	**FACILITY TOTAL**	**NON-FACILITY TOTAL**	**FACILITY PAYMENT**	**NON-FACILITY PAYMENT**
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	90	41.44	N/A	$1,493	N/A
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	90	44.10	N/A	$1,589	N/A
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material;	90	26.36	N/A	$950	N/A
69661	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out	90	34.35	N/A	$1,238	N/A
69662	Revision of stapedectomy or stapedotomy	90	32.95	N/A	$1,187	N/A
69714	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	90	30.47	N/A	$1,098	N/A
69715	Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	90	37.63	N/A	$1,356	N/A
69717	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy	90	31.93	N/A	$1,151	N/A
69718	Replacement (including removal of existing device), osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; with mastoidectomy	90	38.01	N/A	$1,370	N/A
69799	Unlisted procedure, middle ear	YYY*	N/A**	N/A**	At the discretion of the payor***	At the discretion of the payor***
69930	Cochlear device implantation, with or without mastoidectomy	90	34.86	N/A	$1,256	N/A

* 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 2019 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	4.49	N/A	$162	N/A
31527	Laryngoscopy direct, with or without tracheoscopy; with insertion of obturator	0	5.58	N/A	$201	N/A
31528	Laryngoscopy direct, with or without tracheoscopy; with dilation, initial	0	4.13	N/A	$149	N/A
31529	Laryngoscopy direct, with or without tracheoscopy; with dilation, subsequent	0	4.62	4.76	$167	$171
31541	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope or telescope	0	7.55	N/A	$272	N/A
31615	Tracheobronchoscopy through established tracheostomy incision	0	3.29	4.83	$119	$174
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	0	5.71	N/A	$206	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	6.58	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	7.39	N/A	$266	N/A

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.

NOTES

Acclarent, Inc. products are not used in all procedures listed. The most appropriate code for the patient's clinical presentation must be selected. CPT® copyright 2018 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to government use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Sources: Calendar Year 2019 Medicare Outpatient Prospective Payment System, Final Rule [CMS-1695-FC], Federal Register, November 21, 2018 and its associated addenda posted on the Centers for Medicare and Medicaid Services web site on November 1, 2018. 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 2019 Medicare Physician Fee Schedule, Final Rule [CMS-1693-F]. Federal Register, November 23, 2018. No geographic adjustments have been made to the reported payment rates.

STATUS INDICATOR (SI) DEFINITIONS: C - Inpatient only procedure; procedure not paid under OPPS **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. **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.

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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Important information: Prior to use, refer to the instructions for use supplied with this device for indications, contraindications, side effects, warnings and precautions.

Caution: US law restricts this device to sale by or on the order of a physician.

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