2022 OHNS Coding and Reimbursement Guide

***Disclaimer**: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources that may include, but are not limited to, the CPT® coding system, Medicare payment systems, commercially available coding guides, professional societies, and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third-party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When you are making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor, and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.*

The reimbursement rates provided are national Medicare averages published by CMS at the time this guide was created. Reimbursement rates may change due to addendum updates Medicare publishes throughout the year and may not be reflected on the guide.

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If you have any questions, please contact our reimbursement team
at
800.468.1379
or
by e-mail at:

reimbursement@cookmedical.com

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INTRODUCTION

Coverage, coding and payment for medical procedures and devices can be complicated and confusing. This guide was developed to assist with Medicare reporting and reimbursement when performing procedures in which the OHNS products and devices may be used.

COVERAGE

Medicare carriers may issue Local Coverage Decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies http://www.cms.hhs.gov/mcd/search.asp? and contact their carrier's medical director http://www.cms.hhs.gov/apps/contacts/ or commercial insurers to determine if a procedure is covered.

CODING

In the following pages, Cook Medical has suggested codes to be reported by physicians and facilities when reporting services in which our devices are used. It is ultimately up to the billing entity to decide the most appropriate code(s) to report for their services.

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ULTRASOUND-GUIDED THYROID BIOPSY

		Ambulatory Surgery Center	*Outpatient Hospital*		*Physician Services*	
CPT Code	Procedure Description	Facility Payment (National Medicare Avg)[1]	APC	Facility Payment (National Medicare Avg)[2]	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg)[3]	Fee When Procedure Is Performed in Office (National Medicare Avg)[3]
10005	Fine need aspiration biopsy, including ultrasound guidance; first lesion	$322.30	5071	$635.54	$75.10	$142.23
+10006	Fine need aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)	Included in allowance for primary procedure			$51.22	$61.60
60100	Biopsy thyroid, percutaneous core needle	$51.74	5071	$635.54	$77.52	$112.12
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	Imaging is included in allowance for biopsy/ aspiration procedure			$28.03	$116.62
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Imaging is included in allowance for biopsy/ aspiration procedure			$31.15	$59.52

[1] 2022 Medicare Ambulatory Surgery Center Fee Schedule

[2] 2022 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule

[3] 2022 Medicare Physician Fee Schedule

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Elevo®

The Elevo® Snoring Intervention Set is intended for use in stiffening the soft palate tissue, which may reduce the severity of snoring in some individuals. We do not expect insurance plans to reimburse providers for this procedure due to existing non-coverage policies for the treatment of snoring but encourage providers to have this conversation with their local payers. If you have questions, please contact our reimbursement team at 800.468.1379 or by e-mail at reimbursement@cookmedical.com.

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Esophageal Dilation

CPT Code	Procedure Description	Ambulatory Surgery Center: Facility Payment (National Medicare Avg)[1]	Outpatient Hospital: APC	Outpatient Hospital: Facility Payment (National Medicare Avg)[2]	Physician Services: Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg)[3]	Physician Services: Fee When Procedure Is Performed in Office (National Medicare Avg)[3]
43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	$706.87	5302	$1,658.81	$263.35	$1,337.18
43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)	$706.87	5302	$1,658.81	$119.39	$978.66
43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)	$1,400.38	5303	$3,135.90	$187.22	NA*
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	$706.87	5302	$1,658.81	$155.38	$1,180.42

To report esophagogastroscopy where the duodenum is deliberately not examined [eg, judged clinically not pertinent], or because significant situations preclude such exam [eg, significant gastric retention precludes safe exam of duodenum], append modifier -52 if repeat examination is not planned, or modifier -53 if repeat examination is planned.

[1] 2022 Medicare Ambulatory Surgery Center Fee Schedule

[2] 2022 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule

[3] 2022 Medicare Physician Fee Schedule

*Medicare has not developed a rate for the in-office setting because these procedures are typically performed in a hospital or ASC setting. Physicians should contact the Medicare contractor to determine if the service can be performed in office. If the contractor determines the service or procedure may be performed in office, the physician will receive Medicare's physician fee schedule amount for procedures performed in the hospital/ASC.

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Endoscopic Skull Base Surgery

		Ambulatory Surgery Center	Outpatient Hospital		Physician Services	
CPT Code	Procedure Description	Facility Payment (National Medicare Avg)[1]	APC	Facility Payment (National Medicare Avg)[2]	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg)[3]	Fee When Procedure Is Performed in Office (National Medicare Avg)[3]
31290	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region	Procedure not permitted in outpatient setting			$1,175.57	NA*
31291	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region	Procedure not permitted in outpatient setting			$1,236.48	NA*
62165	Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or transsphenoidal approach	Procedure not permitted in outpatient setting			$1,557.28	NA*

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[3] 2022 Medicare Physician Fee Schedule

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Sialendoscopy

CPT Code	Procedure Description	Ambulatory Surgery Center: Facility Payment (National Medicare Avg)[1]	Outpatient Hospital: APC	Outpatient Hospital: Facility Payment (National Medicare Avg)[2]	Physician Services: Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg)[3]	Physician Services: Fee When Procedure Is Performed in Office (National Medicare Avg)[3]
42699*	Unlisted procedure, salivary glands or ducts	This service is not included in Medicare's list of approved procedures	5161	$216.07	Carrier-Priced Procedure	Carrier-Priced Procedure
70390	Sialography, radiological supervision and interpretation	Imaging is included in payment allowance for the sialendoscopy procedure			$18.69	$124.93

* This code will require submission of additional documentation to payers.

Unlisted Procedure Codes

CPT coding convention requires that you "Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the services provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code."[4] As of 2022, a CPT code that accurately describes the sialendoscopy procedure does not exist. As such, the unlisted procedure code 42699-Unlisted procedure, salivary glands or ducts-should be reported to describe this procedure. We encourage facilities to contact their patients' insurance plans for guidance.

Nasal Septal Perforation Repair

CPT Code	Procedure Description	Ambulatory Surgery Center: Facility Payment (National Medicare Avg)[1]	Outpatient Hospital: APC	Outpatient Hospital: Facility Payment (National Medicare Avg)[2]	Physician Services: Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg)[3]	Physician Services: Fee When Procedure Is Performed in Office (National Medicare Avg)[3]
30630	Repair nasal septal perforations	$1,109.32	5164	$2,793.98	$699.05	N/A*

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[2] 2022 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule

[3] 2022 Medicare Physician Fee Schedule

* Medicare has not developed a rate for the in-office setting because these procedures are typically performed in a hospital or ASC setting. Physicians should contact the Medicare contractor to determine if the service can be performed in office. If the contractor determines the service or procedure may be performed in office, the physician will receive Medicare's physician fee schedule amount for procedures performed in the hospital/ASC.

Transnasal Esophageal Dilation

CPT Code	Procedure Description	*Ambulatory Surgery Center* Facility Payment (National Medicare Avg)[1]	*Outpatient Hospital* APC	*Outpatient Hospital* Facility Payment (National Medicare Avg)[2]	*Physician Services* Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg)[3]	*Physician Services* Fee When Procedure Is Performed in Office (National Medicare Avg)[3]
43499*	Unlisted procedure, esophagus	This service is not included in Medicare's list of approved procedures	5301	$826.39	Carrier-Priced Procedure	Carrier-Priced Procedure

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[3] 2022 Medicare Physician Fee Schedule

* This code will require submission of additional documentation to payers.

CPT coding convention requires that you "Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the services provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code." As of 2022, a CPT code that accurately describes a transnasal endoscopic procedure for esophageal dilation does not exist. We encourage facilities to contact their patient's insurance plans for guidance.

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Tympanoplasty and Myringoplasty

CPT Code	Procedure Description	Ambulatory Surgery Center: Facility Payment (National Medicare Avg)[1]	Outpatient Hospital: APC	Outpatient Hospital: Facility Payment (National Medicare Avg)[2]	Physician Services: Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg)[3]	Physician Services: Fee When Procedure Is Performed in Office (National Medicare Avg)[3]
69620	Myringoplasty (surgery confined to drumhead and donor area)	$1,109.32	5164	$2,793.98	$510.10	$774.14
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	$2,445.07	5165	$5,194.27	$924.33	NA*
69632	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction (eg, postfenestration)	$2,445.07	5165	$5,194.27	$1,127.82	NA*
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])	$2,445.07	5165	$5,194.27	$1,092.17	NA*
69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction	$2,445.07	5165	$5,194.27	$1,321.26	NA*
69636	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction	$2,445.07	5165	$5,194.27	$1,467.65	NA*
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])	$2,445.07	5165	$5,194.27	$1,496.72	NA*
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	$2,445.07	5165	$5,194.27	$1,082.48	NA*

Tympanoplasty and Myringoplasty (Cont.)

CPT Code	Procedure Description	Ambulatory Surgery Center: Facility Payment (National Medicare Avg)[1]	Outpatient Hospital: APC	Outpatient Hospital: Facility Payment (National Medicare Avg)[2]	Physician Services: Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg)[3]	Physician Services: Fee When Procedure Is Performed in Office (National Medicare Avg)[3]
69642	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction	$2,445.07	5165	$5,194.27	$1,388.75	NA*
69643	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction	$2,445.07	5165	$5,194.27	$1,270.74	NA*
69644	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, with ossicular chain reconstruction	$2,445.07	5165	$5,194.27	$1,568.01	NA*
69645	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction	$2,445.07	5165	$5,194.27	$1,543.09	NA*
69646	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction	$2,445.07	5165	$5,194.27	$1,633.07	NA*

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2022 physician fees for your local area can be found at the following CMS links:

https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

or

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html