Inferior Turbinoplasty

REIMBURSEMENT CODING GUIDE

This document provides general reimbursement information to assist in obtaining coverage and reimbursement for healthcare services. These coding suggestions do not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. Please contact your local payer for interpretation of the appropriate codes to use for specific procedures.


Please direct any questions to:

Patty Telgener, RN, CPC
Vice President, Reimbursement Services
Emerson Consultants
(303) 526-7604 (office)
pattyt@emersonconsultants.com
INFERIOR TURBINOPLASTY REIMBURSEMENT CODING GUIDE - 2015

ICD-9-CM DIAGNOSIS CODES
ICD-9-CM has a specific diagnosis code to identify hypertrophic turbinates.
478.0   Hypertrophy of nasal turbinates

PHYSICIAN CODING AND REIMBURSEMENT
Physicians use CPT codes to report their services. Payment shown is the Medicare national average and does not include geographical variations.

INFERIOR TURBINOPLASTY
Coding for turbinoplasty procedures centers on whether bone was removed during procedure. Soft tissue reduction of turbinates, without removal of bone, is reported with code 30802. If bone is removed, it is reported with 30140.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2015 Relative Value Unit (RVU)</th>
<th>2015 Medicare Facility Physician Fee Schedule</th>
<th>2015 Relative Value Unit (RVU)</th>
<th>2015 Medicare Non-Facility Physician Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>30802</td>
<td>Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg. electrocautery, radiofrequency ablation, or tissue volume reduction), intramural (ie. submucosal)</td>
<td>5.45</td>
<td>$195</td>
<td>8.29</td>
<td>$296</td>
</tr>
<tr>
<td>30140</td>
<td>Submucous resection inferior turbinate, partial or complete, any method</td>
<td>12.56</td>
<td>$449</td>
<td>12.56</td>
<td>$449</td>
</tr>
</tbody>
</table>

CPT code 30802 is used for both unilateral or bilateral procedures and may be reported only once per operative session. Use of the phrase “any method” in the code definition indicates that the specific instruments and techniques used to accomplish the reduction do not alter the code assignment. Intramural ablation of the turbinates includes any ablation of the superficial tissues so the code for superficial ablation (30801) is not assigned separately with 30802. CPT code 30140 is considered to be unilateral and would be billed with bilateral modifier-50.

OUTFRACTURE OF INFERIOR TURBINA TE

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2015 Medicare Facility Relative Value Unit (RVU)</th>
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<th>2015 Medicare Non-Facility Relative Value Unit (RVU)</th>
<th>2015 Medicare Non-Facility Physician Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>30930</td>
<td>Fracture nasal inferior turbinate(s), therapeutic</td>
<td>3.52</td>
<td>$126</td>
<td>3.52</td>
<td>$126</td>
</tr>
</tbody>
</table>


Despite the “(s)” in its definition, code 30930 is unilateral; physicians should assign bilateral modifier –50 when both the left and right inferior turbinates are outfractured.
INFERIOR TURBINOPLASTY WITH OUTFRACATURE

Turbinoplasty and outfracture are sometimes performed together. According to NCCI edits or CPT descriptions, CPT code 30930 should not be billed with 30140. If CPT codes code 30802 and 30930 are reported together, only one code is paid unless procedures are performed independently on opposite sides.

HOSPITAL OUTPATIENT CODING AND PAYMENT

Hospitals use CPT codes to report outpatient services. Payment shown is for Medicare’s APC hospital outpatient prospective payment system and is the Medicare national average without geographical adjustment. Status Indicator “T” = significant procedure, multiple reduction applies. Payment for each code is made at 100% of the rate when it is the only significant procedure billed. When billed with another status T procedure with higher weight, payment for lower weighted procedures is reduced to 50% of the rate.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>APC</th>
<th>Status Indicator</th>
<th>2015 National Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>30802</td>
<td>Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg. electrocautery, radiofrequency ablation, or tissue volume reduction), intramural (ie. submucosal)</td>
<td>0253 Level IV ENT Procedures</td>
<td>T</td>
<td>$1,267</td>
</tr>
<tr>
<td>30140</td>
<td>Submucous resection inferior turbinate, partial or complete, any method</td>
<td>0254 Level V ENT Procedures</td>
<td>T</td>
<td>$1,946</td>
</tr>
<tr>
<td>30930</td>
<td>Fracture nasal inferior turbinate(s), therapeutic</td>
<td>0254 Level IV ENT Procedures</td>
<td>T</td>
<td>$1,946</td>
</tr>
</tbody>
</table>

2. CMS Final 2015 Outpatient Rule - CMS-1613-FC. Fee schedules are national averages and are not geographically adjusted.
3. Status indicator “T” means “significant procedure, multiple procedure reduction applies”

NCCI edits apply to hospital coding as well as physician coding. If inferior turbinoplasty and outfracture are performed together on the same side, hospitals should report only 30930 for outfracture.

AMBULATORY SURGERY CENTER CODING AND PAYMENT

Medicare payment for procedures performed in an ASC are based on the APC methodology for hospital outpatient payment. CPT codes 30802 and 30930 are designated as ASC Covered Surgical Procedures for CY 2015.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Payment Indicator</th>
<th>Multiple Procedure Discounting</th>
<th>2015 National Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>30802</td>
<td>Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg. electrocautery, radiofrequency ablation, or tissue volume reduction), intramural (ie. submucosal)</td>
<td>A2</td>
<td>Yes</td>
<td>$694</td>
</tr>
<tr>
<td>30140</td>
<td>Submucous resection inferior turbinate, partial or complete, any method</td>
<td>A2</td>
<td>Yes</td>
<td>$1,066</td>
</tr>
<tr>
<td>30930</td>
<td>Fracture nasal inferior turbinate(s), therapeutic</td>
<td>A2</td>
<td>Yes</td>
<td>$1,066</td>
</tr>
</tbody>
</table>

2. CMS Final 2015 Outpatient Rule - CMS-1613-FC. Fee schedules are national averages and are not geographically adjusted.
Multiple procedure discounting indicates that the procedures are subject to standard multiple procedure rules when performed together; one procedure is paid at 100% of the rate and the other is paid at 50% of the rate. Payment Indicator A2 means “Surgical procedure with transitional payment based on hospital outpatient relative payment weight”

PAYMENT
Commercial payers may use Medicare’s methodology or a similar type of fee schedule to reimburse hospitals or ambulatory surgery centers for outpatient services. Providers should contact commercial payers for specific payment methodologies.

A NOTE ABOUT BLADES AND OTHER DISPOSABLES
Blades and other disposables are not separately payable for Medicare. For physicians, the items are part of the practice expense component of the RBRVS payment. For hospitals, they are included in the APC payment or DRG. Commercial payers also generally do not pay separately for blades and other disposables, unless the payer-provider contract has a specific provision for them.