Medtronic

Nasal and sinus procedures

2026 coding and payment guide

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Physician coding and payment

January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[1]	Medicare work RVUs[2,a]	Medicare national average for physician services provided in:[†,3]	
			Office	Facility
Computerized tomography[b]	**70480** Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material (CT of outer, middle or inner ear)	1.25	$158	NA
	70486 Computed tomography, maxillofacial area, without contrast material	0.83	$128	NA
Surgical navigation[c]	**61782** Stereotactic computer-assisted (navigational) procedure, cranial, extradural	3.1	NA[d]	$144
Inferior turbinate resection/ ablation, rhinoplasty, septoplasty, and sinus lavage[e]	**30110** Excision nasal polyp(s), simple	1.64	$247	$120
	30115 Excision nasal polyp(s), extensive	4.33	NA	$434
	30140 Submucous resection, inferior turbinate, partial or complete, any method[f]	2.93	$294	$153
	30220 Insertion, nasal septal prosthesis (button)	1.55	$300	$116
	30420 Rhinoplasty, primary; including major septal repair	16.48	NA	$1,313
	30465 Repair of nasal vestibular stenosis (e.g. spreader grafting, lateral nasal wall reconstruction)[g,h]	12.05	NA	$923
	30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft[h]	6.83	NA	$614
	30620 Septal or other intranasal dermatoplasty	6.01	NA	$618
	30630 Repair nasal septal defect	7.11	NA	$608
	30801 Cautery and/ or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial	1.11	$219	$140
	30802 Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g. electrocautery, radiofrequency ablation, or tissue volume reduction), intramural (i.e. submucosal)[f]	2.03	$279	$183
	30930 Fracture nasal inferior turbinate(s), therapeutic[f]	1.28	NA	$109
	31000 Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	1.17	$1889	$102
	31002 Lavage by cannulation; sphenoid sinus (antrum puncture or natural ostium)	1.91	NA	$167
Nasal/sinus endoscopy[e,i]	**31231** Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	1.07	$193	$55
	31233 Diagnostic endoscopy of nose and maxillary sinus via inferior meatus puncture	2.13	$273	$117
	31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridements (separate procedure)	2.54	$267	$138

[†] Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

Nasal/sinus endoscopy[e,i] (continued)	**31238** Surgical endoscopy of nose with control of nasal hemorrhage	2.67	$260	$144
	31240 Nasal/sinus endoscopy, surgical; with concha bullosa resection	2.54	NA	$137
	31241 Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	7.80	NA	$373
	31253 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including frontal sinus exploration; with or without removal of tissue from frontal sinus	8.78	NA	$420
	31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	4.16	$437	$206
	31255 Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	5.61	NA	$273
	31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy	3.03	NA	$153
	31257 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy	7.80	NA	$375
	31259 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy, with removal of tissue from sphenoid sinus	8.27	NA	$397
	31267 Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	4.56	NA	$224
	31276 Nasal/sinus endoscopy, surgical with frontal sinus exploration; with or without removal of tissue from frontal sinus	6.58	NA	$318
	31287 Nasal/sinus endoscopy, surgical, with sphenoidotomy	3.41	NA	$170
	31288 Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	4.00	NA	$198
	31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	2.63	$1,579	$135
	31296 Nasal/sinus endoscopy, surgical: with dilation of frontal sinus ostium (e.g. balloon dilation)	3.02	$1,604	$152
	31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g. balloon dilation)	2.38	$1,566	$124
	31298 Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostium (e.g. balloon dilation)	4.39	$2,968	$216
	NOTE: CPT codes 31295, 31296, 31297 and 31298 apply to cases in which a balloon catheter is the only instrument or tool used and no tissue is removed. Do not report 31295, 31296, 31297, or 31298 with endoscopic sinus surgery codes when performed on the same sinus.			
Balloon Dilation of Eustachian Tube (BDET)	**69705** Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); unilateral	2.93	$2,571	$148
	69706 Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); bilateral	4.16	$2,662	$205
	NOTE: Based on Medicare NCCI Procedure to Procedure edits, CPT codes 30801, 30802 or 31231 should not be reported with CPT codes 69705 and 69706. For distinct and separate services, the use of an appropriate modifier may be applicable. Please consult with your local Medicare Administrative Contractor accordingly.			

HCPCS II device codes

Device C-codes

Device	HCPCS II device codes[4,j]	HCPCS II code description / comment
ENT Slide-On™ Endosheath™ System[k]	A4270	Disposable endoscope sheath, each
NuVent™ EM Sinus Dilation System[k]	C1726	Catheter, balloon dilation, non-vascular
NuVent™ Eustachian Tube Dilation Balloon[k]	C1726	Catheter, balloon dilation, non-vascular
Novapak™ Nasal Sinus Packing and Stent[k]	C1763	Connective tissue, non-human (includes synthetic)
MeroGel™ Bioresorbable Nasal Packing Products[k]	C1763	Connective tissue, non-human (includes synthetic)
MeroPack™ Bioresorbable Nasal Dressing and Sinus Stent[k]	C1763	Connective tissue, non-human (includes synthetic)
Chitogel™ Endoscopic Sinus Surgery Kit[k]	C1763	Connective tissue, non-human (includes synthetic)
HydroCleanse™ Sinus Wash Delivery System & Hydrodebrider™ Endoscopic Sinus Irrigation System[k]	N/A[l]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
Nasal Septal Button	N/A[l]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
Powered Surgical Equipment: Console, Microdebrider, Burs & Blades	N/A[l]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
ENT Navigation System: Instruments & Accessories	N/A[l]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.
PROPEL™ mometasone furoate sinus implants	C2625[m]	Stent, non-coronary, temporary, with delivery system
PROPEL™ mometasone furoate sinus implants	S1091[m]	Stent, non-coronary, temporary, with delivery system (propel)

The device C-codes above are applicable to this therapy. To determine if there is a C-code for a particular Medtronic device, click here for a C-code finder to search by model number, product name, C-code, C-code description, or product category.

HCPCS II drug codes

Drug codes

Drug	HCPCS II drug codes[4]	HCPCS II code description / comment
SINUVA™ (mometasone furoate) sinus implant	J7402[n]	Mometasone furoate sinus implant, (sinuva), 10 micrograms

Hospital outpatient coding and payment

Effective January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[1]	APC[5,o]	APC level	Status indicator[p]	Relative weight[5]	Medicare national average[5]
Computerized tomography	**70480** Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material (CT of outer, middle or inner ear)	5522	Level 2	Q3	1.1684	$107
	70486 Computed tomography, maxillofacial area, without contrast material	5522	Level 2	Q3	1.1684	$107
Surgical navigation[c]	**61782** Stereotactic computer-assisted (navigational) procedure, cranial, extradural	N/A	N/A	N	N/A	N/A
Inferior turbinate resection/ ablation, rhinoplasty, septoplasty, and sinus lavage[e]	**30110** Excision nasal polyp(s), simple	5163	Level 3	J1	17.3406	$1,585
	30115 Excision nasal polyp(s), extensive	5164	Level 4	J1	37.0538	$3,387
	30140 Submucous resection, inferior turbinate, partial or complete, any method[f]	5164	Level 4	J1	37.0538	$3,387
	30220 Insertion, nasal septal prosthesis (button)	5163	Level 3	J1	17.3406	$1,585
	30420 Rhinoplasty, primary; including major septal repair	5165	Level 5	J1	66.1604	$6,048
	30465 Repair of nasal vestibular stenosis (e.g. spreader grafting, lateral nasal wall reconstruction)[g,h]	5165	Level 5	J1	66.1604	$6,048
	30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft[h]	5164	Level 4	J1	37.0538	$3,387
	30620 Septal or other intranasal dermatoplasty	5165	Level 5	J1	66.1604	$6,048
	30630 Repair nasal septal defect	5164	Level 4	J1	37.0538	$3,387
	30801 Cautery and/ or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial	5163	Level 3	J1	17.3406	$1,585
	30802 Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g. electrocautery, radiofrequency ablation, or tissue volume reduction), intramural (i.e. submucosal)[f]	5163	Level 3	J1	17.3406	$1,585
	30930 Fracture nasal inferior turbinate(s), therapeutic[f]	5164	Level 4	J1	37.0538	$3,387
	31000 Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	5161	Level 1	T	2.6471	$242
	31002 Lavage by cannulation; sphenoid sinus (antrum puncture or natural ostium)	5163	Level 3	J1	17.3406	$1,585
Nasal/sinus endoscopy[e,i]	**31231** Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	5151	Level 1	T	2.2308	$204
	31233 Diagnostic endoscopy of nose and maxillary sinus via inferior meatus puncture	5152	Level 2	T	4.3712	$400
	31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridements (separate procedure)	5153	Level 3	J1	19.8922	$1,818
	31238 Surgical endoscopy of nose with control of nasal hemorrhage	5153	Level 3	J1	19.8922	$1,818
	31240 Nasal/sinus endoscopy, surgical; with concha bullosa resection	5153	Level 3	J1	19.8922	$1,818
	31241 Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	5153	Level 3	J1	19.8922	$1,818

Nasal/sinus endoscopy[e,i] (continued)	**31253** Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including frontal sinus exploration; with or without removal of tissue from frontal sinus	5155	Level 5	J1	78.8746	$7,210
	31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	5155	Level 5	J1	78.8746	$7,210
	31255 Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	5155	Level 5	J1	78.8746	$7,210
	31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy	5154	Level 4	J1	41.6682	$3,809
	31257 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy	5155	Level 5	J1	78.8746	$7,210
	31259 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy, with removal of tissue from sphenoid sinus	5155	Level 5	J1	78.8746	$7,210
	31267 Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	5155	Level 5	J1	78.8746	$7,210
	31276 Nasal/sinus endoscopy, surgical with frontal sinus exploration; with or without removal of tissue from frontal sinus	5155	Level 5	J1	78.8746	$7,210
	31287 Nasal/sinus endoscopy, surgical, with sphenoidotomy	5155	Level 5	J1	78.8746	$7,210
	31288 Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	5155	Level 5	J1	78.8746	$7,210
	31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	5155	Level 5	J1	78.8746	$7,210
	31296 Nasal/sinus endoscopy, surgical: with dilation of frontal sinus ostium (e.g. balloon dilation)	5155	Level 5	J1	78.8746	$7,210
	31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g. balloon dilation)	5155	Level 5	J1	78.8746	$7,210
	31298 Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostium (e.g. balloon dilation)	5155	Level 5	J1	78.8746	$7,210
	NOTE: CPT codes 31295, 31296, 31297 and 31298 apply to cases in which a balloon catheter is the only instrument or tool used and no tissue is removed. Do not report 31295, 31296, 31297, or 31298 with endoscopic sinus surgery codes when performed on the same sinus					
Balloon dilation of eustachian tube (BDET)	**69705** Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); unilateral	5165	Level 5	J1	66.1604	$6,048
	69706 Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); bilateral	5165	Level 5	J1	66.1604	$6,048
	NOTE: Based on Medicare NCCI Procedure to Procedure edits, CPT codes 30801, 30802 or 31231 should not be reported with CPT codes 69705 and 69706. For distinct and separate services, the use of an appropriate modifier may be applicable. Please consult with your local Medicare Administrative Contractor accordingly.					

ASC coding and payment

January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[1,q]	Payment indicator[r]	Multiple procedure discounting[s]	Relative weight[6]	Medicare national average[6]
Computerized tomography	**70480** Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material (CT of outer, middle or inner ear)	Z2	N	1.0127	$57
	70486 Computed tomography, maxillofacial area, without contrast material	Z2	N	1.0127	$57
Surgical navigation[c]	**61782** Stereotactic computer-assisted (navigational) procedure, cranial, extradural	N1	N	N/A	N/A
Inferior turbinate resection/ ablation, rhinoplasty, septoplasty, and sinus lavage[e]	**30110** Excision nasal polyp(s), simple	P3	Y	N/A	$185
	30115 Excision nasal polyp(s), extensive	A2	Y	26.2864	$1,481
	30140 Submucous resection, inferior turbinate, partial or complete, any method[f]	A2	Y	26.2864	$1,481
	30220 Insertion, nasal septal prosthesis (button)	A2	Y	11.7036	$659
	30420 Rhinoplasty, primary; including major septal repair	A2	Y	53.7200	$3,026
	30465 Repair of nasal vestibular stenosis (e.g. spreader grafting, lateral nasal wall reconstruction)[g,h]	A2	Y	53.7200	$3,026
	30520 Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft[h]	A2	Y	26.2864	$1,481
	30620 Septal or other intranasal dermatoplasty	A2	Y	53.7200	$3,026
	30630 Repair nasal septal defect	A2	Y	26.2864	$1,481
	30801 Cautery and/ or ablation, mucosa of inferior turbinates, unilateral or bilateral, any method; superficial	A2	Y	11.7036	$659
	30802 Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (e.g. electrocautery, radiofrequency ablation, or tissue volume reduction), intramural (i.e. submucosal)[f]	A2	Y	11.7036	$659
	30930 Fracture nasal inferior turbinate(s), therapeutic[f]	A2	Y	26.2864	$1,481
	31000 Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)	P2	Y	2.2992	$130
	31002 Lavage by cannulation; sphenoid sinus (antrum puncture or natural ostium)	R2	Y	11.7036	$659
Nasal/sinus endoscopy[e,i]	**31231** Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)	P2	Y	1.9482	$110
	31233 Diagnostic endoscopy of nose and maxillary sinus via inferior meatus puncture	A2	Y	3.8141	$215
	31237 Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridements (separate procedure)	A2	Y	14.9811	$844
	31238 Surgical endoscopy of nose with control of nasal hemorrhage	A2	Y	14.9811	$844
	31240 Nasal/sinus endoscopy, surgical; with concha bullosa resection	A2	Y	14.9811	$844
	31241 Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery	G2	Y	14.9811	$844

Nasal/sinus endoscopy[e,i] (continued)	**31253** Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including frontal sinus exploration; with or without removal of tissue from frontal sinus	G2	Y	43.5180	$2,451
	31254 Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	A2	Y	43.5180	$2,451
	31255 Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)	A2	Y	43.5180	$2,451
	31256 Nasal/sinus endoscopy, surgical, with maxillary antrostomy	A2	Y	30.1201	$1,696
	31257 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy	G2	Y	43.5180	$2,451
	31259 Nasal/sinus endoscopy, surgical with ethmoidectomy, total (anterior and posterior) including sphenoidotomy, with removal of tissue from sphenoid sinus	G2	Y	43.5180	$2,451
	31267 Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus	A2	Y	43.5180	$2,451
	31276 Nasal/sinus endoscopy, surgical with frontal sinus exploration; with or without removal of tissue from frontal sinus	A2	Y	43.5180	$2,451
	31287 Nasal/sinus endoscopy, surgical, with sphenoidotomy	A2	Y	43.5180	$2,451
	31288 Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus	A2	Y	43.5180	$2,451
	31295 Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g. balloon dilation), transnasal or via canine fossa	J8	Y	55.1380	$3,105
	31296 Nasal/sinus endoscopy, surgical: with dilation of frontal sinus ostium (e.g. balloon dilation)	P3	Y	0.0000	$1,496
	31297 Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g. balloon dilation)	J8	Y	55.2692	$3,113
	31298 Nasal/sinus endoscopy, surgical; with dilation of frontal and sphenoid sinus ostium (e.g. balloon dilation)	P2	Y	43.5180	$2,451
	NOTE: CPT codes 31295, 31296, 31297 and 31298 apply to cases in which a balloon catheter is the only instrument or tool used and no tissue is removed. Do not report 31295, 31296, 31297, or 31298 with endoscopic sinus surgery codes when performed on the same sinus				
Balloon dilation of eustachian tube (BDET)	**69705** Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); unilateral	J8	Y	74.3890	$4,190
	69706 Nasopharyngoscopy, surgical, with dilation of the eustachian tube (i.e balloon dilation); bilateral	J8	Y	76.6887	$4,319
	NOTE: Based on Medicare NCCI Procedure to Procedure edits, CPT codes 30801, 30802 or 31231 should not be reported with CPT codes 69705 and 69706. For distinct and separate services, the use of an appropriate modifier may be applicable. Please consult with your local Medicare Administrative Contractor accordingly.				

Annual references

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2. PFS 2026 Final Rule CMS-1832-F Addenda. Cms.gov. Published October 31, 2025. https://www.cms.gov/files/zip/cy-2026-pfs-final-rule-addenda.zip. Although the total RVU consists of three components, only the physician work RVU is shown.
3. PFS 2026 Final Rule CMS-1832-F | CMS. Cms.gov. Published October 31, 2025. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f. Local physician rates will vary based on location specific factors not reflected in this document.
4. HCPCS 2025 Level II Professional Edition. American Medical Association; 2024. These codes are used by the entity that purchased and supplied the medical device. For Medicare hospital outpatient claims, C codes are required. For Medicare ASC claims, C codes are not reported unless the device is eligible for transitional pass-through payment. For non-Medicare hospital or ASC claims, please consult payer specific contracts for whether the C code would be billed.
5. OPPS 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc. Rates shown reflect the unadjusted OPPS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
6. ASC 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1834-fc. Rates shown reflect the unadjusted ASC payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.

Important information

a. Physicians use CPT codes for all services. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the relative value unit (RVU), which is then converted to a flat payment amount.

b. Allowable rate includes both the technical and professional components. When billing for professional service only, a 52 modifier would be added and allowable rate would be reduced accordingly.

c. As medically necessary, the use of a stereotactic guidance system may be reported in addition to the appropriate codes for the primary ENT procedure. Documentation should explain both the medical necessity and pre-planning activities. CPT code 61782 is an "add-on" code and must be reported in addition to the primary procedure.

d. "N/A" shown in Physician Office setting indicates that Medicare has not developed RVUs in the office setting because the service is typically performed in a facility (e.g.in a hospital). However, if the local contractor determines that it will cover the service in the office, then it is paid using the facility RVUs at the facility rate.

e. Modifier -50 is used to report bilateral procedures that are performed at the same operative session as a single line item. Do not use modifiers RT and LT when modifier -50 applies. Do not submit two line items to report a bilateral procedure using modifier -50 . If a procedure is identified by the terminology as bilateral (or "unilateral or bilateral"), as in codes 30801 and 30802, physicians do not report the procedure with modifier "-50."

f. Coding for turbinoplasty procedures is based 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. Turbinoplasty and outfracture are sometimes performed together. According to NCCI edits and/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.

g. CPT 30465 is used to report a bilateral procedure. For unilateral procedure, use modifier -52.

h. You may also report a separate code when you harvest graft material through a separate incision (e.g. 20912- Cartilage graft; nasal septum). However, if a septoplasty (CPT 30520) is performed and reported during the same operative session, then you may not separately report graft harvest.

i. Special rules for multiple endoscopic procedures apply when nasal/sinus endoscopy procedures are billed together for the same patient on the same day. Multiple endoscopic payment rules apply to a code family before ranking the family with other procedures performed on the same day. When a nasal/sinus endoscopy procedure is reported together with its base procedure, CPT 31231, then, payment for the base procedure is included in the payment for the other nasal/sinus endoscopy procedure.

j. These codes are used by the entity that purchased and supplied the medical device, DME drug, or supply to the patient. Medicare provides C-codes for hospital use in billing Medicare for medical devices in the outpatient setting. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers. ASCs however, usually should not assign or report HCPCS II device codes for devices on claims sent to Medicare. Medicare generally does not make a separate payment for devices in the ASC. Instead, payment is "packaged" into the payment for the ASC procedure. ASCs are specifically instructed not to bill HCPCS II device codes to Medicare for devices that are packaged.

k. Slide-On™, EndoSheath™, NuVent™, MeroGel™, MeroPack™, Novapak™, HydroCleanse™, Hydrodebrider™ are trademarks of Medtronic, Inc. Chitogel™ is distributed by Medtronic, Inc.

l. N/A indicates that CMS and other payers do not have a need for these items to be individually identified, although the associated charges must still be reported. When hospitals use a device or supply that does not have a HCPCS II code, they should report the charges in the general revenue code for the item, typically revenue code 270 for Medical-Surgical Supplies.

m. The appropriate HCPCS code for PROPEL™ mometasone furoate sinus implants depends on the payer and place of service. Use C2625 for Medicare and some commercial payers in the hospital outpatient and ASC settings (POS 19, 22, or 24), but verify whether it is reportable with the specific procedure in the ASC setting. For commercial payers, S1091 is typically used and should be billed as one unit per package; S1091 is also appropriate for office settings (POS 11). If the payer does not accept C2625, consider S1091 as an alternative. Medicare does not provide separate payment for C2625 in the hospital outpatient setting, but hospitals should still report it for rate setting purposes. Always confirm with the payer to ensure the correct code is used.

n. J7402 billable units are 1 unit for every 10 mcg = 135 billing units

o. Hospitals use CPT codes for outpatient services. Under Medicare's APC (Ambulatory Payment Classification) methodology for hospital outpatient payment, each CPT code is assigned to an APC. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can sometimes be assigned for each encounter, depending on the number of procedures coded and whether any of the procedure codes map to a Comprehensive APC (C-APC). A CPT procedure code assigned to a C-APC is considered a primary service, and all other procedures and services coded on the bill are considered adjunctive to delivery of the primary service. This results in a single APC payment and a single beneficiary copayment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for any other adjunctive services. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive services, which are packaged into the payment for the primary service. When more than one primary service is coded for the same outpatient encounter, the codes are ranked according to a fixed hierarchy. The C-APC is then assigned according to the highest ranked code. In some special circumstances, the combination of two primary services leads to a "complexity adjustment" in which the entire encounter is re-mapped to another higher-level APC. As shown in the tables below, the procedures that are subject to C-APCs are identified by status indicator J1.

p. Status Indicator (SI) shows how a code is handled for payment purposes: J1 = paid under a comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; N = packaged service, no separate payment; T = Significant procedure subject to multiple procedure discounting; Q3 = code that may be paid through a composite APC.

q. ASCs (Ambulatory Surgery Centers) also use CPT codes for their services. Medicare payment for procedures performed in an ASC is based on the APC methodology for hospital outpatient payment. However, C-APCs are used only for hospital outpatient services and are not applied to procedures performed in ASCs. Each CPT code designated as a covered procedure in an ASC is assigned a comparable weight as under the hospital outpatient APC system. This is then converted to a flat payment amount using a conversion factor unique to ASCs. Multiple procedures can be paid on each claim. Certain ancillary services, such as imaging, are also covered when they are integral to covered surgical procedures, although they may not be separately payable. In general, there is no separate payment for devices; their payment is packaged into the payment for the procedure.

r. The Payment Indicator shows how a code is handled for payment purposes: A2= Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight. G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC. J8 = device-intensive procedure, payment amount adjusted to incorporate device cost. N1= Packaged service/item; no separate payment made. P2= office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility 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 MPFS non-facility PE RVUs. R2= Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS non-facility PE RVUs; payment based on OPPS relative payment weight.

s. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedure and 50% of the rate for the second and all subsequent procedures. These procedures are marked "Y". However, procedures marked "N" are not subject to this discounting and are paid at 100% of the rate regardless of whether they are submitted with other procedures.

Indications, contraindications, and precautions

The PROPEL™ sinus implants are intended to maintain patency and locally deliver steroid to the sinus mucosa in patients ≥18 years of age following sinus surgery: PROPEL™ for the ethmoid sinus, PROPEL™ mini for the ethmoid sinus/frontal sinus opening, and PROPEL™ contour for the frontal/maxillary sinus ostia. Contraindications include patients with confirmed hypersensitivity or intolerance to mometasone furoate (MF) or hypersensitivity to bioabsorbable polymers. Safety and effectiveness of the implant in pregnant or nursing females have not been studied. Risks may include, but are not limited to, pain/pressure, displacement of the implant, possible side effects of intranasal MF, sinusitis, epistaxis, and infection. For full prescribing information, see IFU at manuals.medtronic.com. Rx only.

INDICATION

SINUVA Sinus Implant is a corticosteroid-eluting implant indicated for the treatment of chronic rhinosinusitis with nasal polyps in adult patients ≥ 18 years of age who have had ethmoid sinus surgery.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

Patients with known hypersensitivity to mometasone furoate and any of the ingredients of the SINUVA Sinus Implant.

WARNINGS AND PRECAUTIONS

Local Nasal Adverse Reactions: Monitor nasal mucosa adjacent to the SINUVA Sinus Implant for any signs of bleeding (epistaxis), irritation, infection, or perforation. Avoid use in patients with nasal ulcers or trauma.

Glaucoma and Cataracts: Nasal steroids may result in development of glaucoma and/or cataracts. Glaucoma, cataracts, and clinically significant elevation of intraocular pressure were not observed in patients from the treatment group of one randomized controlled clinical study (N = 53) who underwent bilateral placement of SINUVA Sinus Implants. Close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma, and/or cataracts.

Hypersensitivity Reactions: Hypersensitivity reactions, including rash, pruritus, and angioedema have been reported with the use of corticosteroids.

Immunosuppression and Risk of Infections (BOLD): Persons who are using drugs that suppress the immune system, such as corticosteroids, including SINUVA Sinus Implant are more susceptible to infections than healthy individuals. The safety and effectiveness of SINUVA Sinus Implant have not been established in pediatric patients less than 18 years of age and SINUVA is not indicated for use in this population. Corticosteroids should be used with caution, if at all, in patients with active or quiescent tuberculosis infection of the respiratory tract; untreated systemic fungal, bacterial, viral, or parasitic infections; or ocular herpes simplex.

Hypercorticism and Adrenal Suppression: If corticosteroid effects such as hypercorticism and adrenal suppression appear in patients, consider sinus implant removal.

ADVERSE REACTIONS

The most common adverse reactions observed (> 1% of subjects) in clinical studies were asthma, headache, epistaxis, presyncope, bronchitis, otitis media, and nasopharyngitis.

POSTMARKETING EXPERIENCE

The following adverse reactions have been identified during post-approval use of the SINUVA sinus implant. These events include implant migration, lack of efficacy, nasal pain, headache, epistaxis.

Rx only. Please see Full Prescribing Information for SINUVA available at http://medtronic.com/sinuva.