

RELTOK NASAL PRODUCTS - CPT CODE 30999-BR EXPLANATION

Used to Bill for Surgeon's Professional Fee For Insertion / Removal of Intranasal Airway

Whoever Says They Cannot Be Paid for Using this Code is Wrong

- Some insurance billers are reluctant to submit an insurance claim using a “___999-BR (By Report) code based on a lack of understanding with the process. The refrain “*We’ll never get paid for that*” is simply untrue.
- Surgeons will be paid when their billing teams follow the proper process. For six years, surgeons throughout the US have been paid a professional fee thousands of times for inserting the airway. They just followed the right process.
- There is nothing improper, illegal or unethical about using such a code.
- The Current Procedural Terminology (CPT) code system was instituted decades ago. The common procedures, such as nasal septoplasty, recognized as “universal use” each bear a five-digit code number; for example, nasal septoplasty, 30520.

The CPT Coding System Provides Payment Provision for Installation of New Devices

- What happens when modern science and technology introduce a new device or product? Or breakthrough surgical technique or medical treatment? Adoption by thousands of practitioners can take years. At some point, when it can be shown to the American Medical Association (AMA), the central registry for the ICD roster of diagnoses and the CPT roster for treatments, that there is “universal usage”, then a five-digit CPT code for the procedure or technique will be assigned. Until that tipping point is reached, the doctor is not penalized. There is a provision for the identification of such a procedure or technique, prior to acceptance and usage by the great majority of practitioners.
- AMA has made provisions for identifying such new technology, new surgical procedures, and utilization of a new device or product. New or “unlisted procedures”, in the world of nasal surgery, are coded “30999-BR (by report)”. The “30” identifies a nasal procedure. In the world of abdominal surgery, the “500” series is used, so the analogous “new procedure performed on the abdomen, would be “50999-BR”. The insurers deserve and need to know, in a written report, all about this new product, procedure, et al. The “report” tells the insurer this is a new procedure, or use of a new product, for nasal surgery, not yet in universal use but qualified. The key to “qualification” is that there is FDA clearance. The FDA, not the insurance company, is the arbiter of what is considered safe. The implication is that if the product, device or service is safe, the insurer is obliged to honor the charge.

It Takes Seconds to Complete the Billing Form and Copy/Paste the Details of the Airway Device Insertion into an Operative Report

- There is a dedicated space on the universal billing form, “Box 19”, into which the biller need only state the qualification or “stamp of approval” which renders the charge eligible for payment. For the Reltok Clear-Flo™ Nasal Airway, an FDA-cleared device, holding two distinct patents, the appropriate message to the insurer, entered into **Box 19** is “**FDA-cleared safety device**”. ([See Sample Billing Form below](#))
- The only other distinct requirement for consideration for payment is that a report, either separate or included within the operative report needs to explain the nature of the new procedure, why it is being done, how it is performed, along with the expectations and benefits for patients. With that in hand, the insurer’s obligation will be met. ([See Operative Report Instructions below](#))

- Reltok Nasal Products offers templated forms, which have been used by many practices in thousands of cases, that provides all the information and explanations for facilitating payment for “Insertion of intranasal airway”. These are detailed, comprehensive and have been proven to be appropriate and satisfactory by most major insurers, including Medicare.

Intention to Insert the Airway is Not Required Within a Pre-Authorization

- The surgeon needs permission only to perform the main surgical procedure.
- The above are “the rules” of insurance billing for a new device. The first time an artificial heart valve or vascular prosthesis was submitted for insurance payment, the same rules of the road had to be filed. Just a different “__999-BR code was surely used.

Remember, the companies that manufacture new, high-tech “devices” like sinus surgery scanners, or even balloon sinuplasty or drug eluding stents all provide billing guidance documents for their customers. All are intended to help facilitate the billing process so that doctors have time to practice medicine and not duel with insurance companies.

Sample Billing Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

INSURANCE MEDICARE MEDICAID PRIVATE OTHER (Check one)

PATIENT'S NAME (Last Name, First Name, Middle Initial) DOB JOHN 01 01 1980 SEX M

PATIENT'S ADDRESS (incl. Street) 1200 GREEN STREET HOLLYWOOD CA 90046

INSURANCE POLICY OR GROUP NUMBER 90046 (223) 222 2222

INSURANCE PLAN NAME OR PROGRAM NAME

DATE OF BIRTH 01 01 1980 SEX M

DATE OF SERVICE 05 14 2019

NUCC Instruction Manual available at: www.nucc.org

Operative Report Instructions

Operative Report Instructions for Billing Purposes

Step 1:

Add the following information to your Operative Report for the intranasal airway:

Procedure: Insertion and Fixation Intranasal airway prosthesis

CPT Code: 30999-BR

Step 2:

Insert the following information into your operative report to provide the appropriate details about the intranasal airway prosthesis:

Insertion and Fixation of Intranasal AIRWAY Prosthesis

Mission of the Inserted AIRWAY Prosthesis: The mission of said prosthetic device is to provide a secure, safe and practical post-operative AIRWAY to prevent asphyxiation in the operating room and recovery room and render a safer and satisfactory post-operative recovery for the nasal/sinus surgery patient.

The device holds two U.S. patents and is FDA-cleared to serve the anesthesiologist and recovery room staff. This AIRWAY device provides a rapid, safe and direct route to the pharynx—despite both nasal cavities being otherwise completely occluded—for aspiration of secretions as the operation is ending and the patient is emerging from the anesthetic. It allows the anesthesiologist and recovery nurse a route to clear the nasal airway, and thus prevent obstruction, cardiac and respiratory complications, including asphyxiation, without patient cooperation.

Technique of Insertion and Testing for Patency

The sterile intranasal airway prosthesis was prepared for insertion. Each of the dual tube soft-silicone nasal airway prosthesis was lubricated and inserted into the nasal cavity under direct inspection. After the entire device was within the nasal cavity, using a narrow nasal speculum and bayonet forceps, each member of the dual-airway prosthesis was manipulated into its nesting place into the floor of each nasal passage. It was seen to be properly positioned and fixed on the nasal floor, between the pre-mastoid nasal crest portion of the inferior bony septum and the inferior turbinate. The stability and immobility were confirmed using the forceps. The device's external bridge sat properly over the face of the columella to prevent retro-displacement of the prosthesis.

Bilateral airway patency was then confirmed by irrigation with sterile saline solution. In anticipation of the anesthesiologist's forthcoming suction-aspiration of the naso- and oropharynxes, to confirm airway patency, a standard, sterile 10 ft. suction catheter was passed through each of airway tubes. The stagnant and obstructing blood and mucus were thus evacuated from the pharynxes.

At the very conclusion of the procedure, before extubation and emergence, the anesthesiologist accessed the pharynx, via this now-fixed, indwelling bilateral nasal airway, to aspirate any potentially airway-obstructing secretions/ fluids.

Recovery Room Mission of the AIRWAY Prosthesis

The rationale for placement and utilization of the airway prosthesis is that as the patient emerges from anesthesia, with such access to the pharynx by the anesthesiologist assured, there is less chance of aspiration, airway obstruction and potentially onerous complications, including asphyxiation, particularly in the recovery room where the patient is under the residual effect of the anesthesia, and the pharynx is yet topically anesthetized. Hence the protective reflexes that would otherwise protect the trachea and lungs are absent, an inherently risky situation should secretions not be removed.

Click on documents to view.