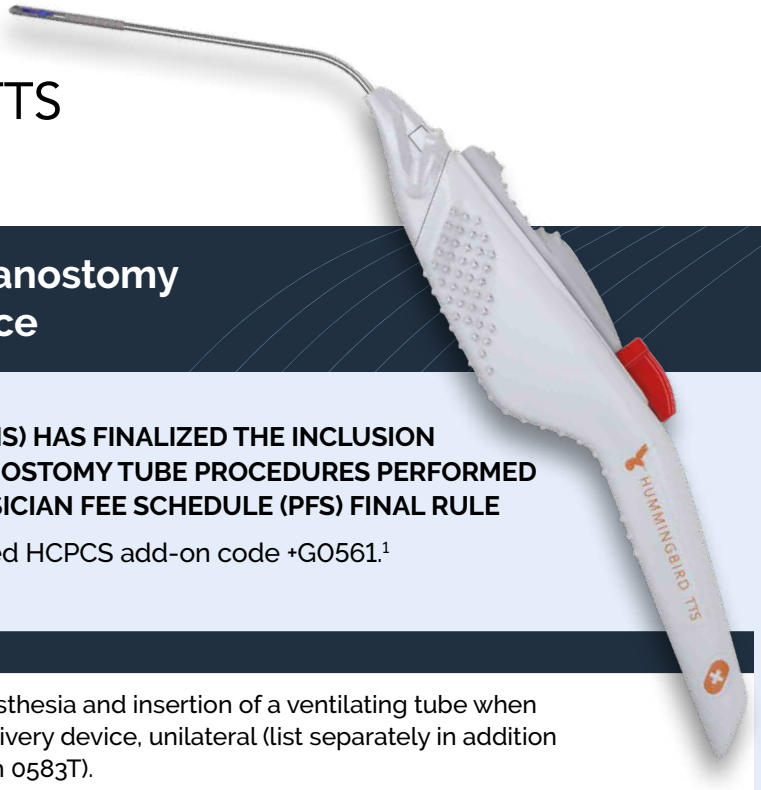
HUMMINGBIRD® TTS

TYMPANOSTOMY TUBE SYSTEM



Add-on G-code for Pediatric Tympanostomy Tube Procedures Performed in Office

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) HAS FINALIZED THE INCLUSION OF A NEW ADD-ON G-CODE FOR PEDIATRIC TYMPANOSTOMY TUBE PROCEDURES PERFORMED IN OFFICE AS PART OF THE CY 2025 MEDICARE PHYSICIAN FEE SCHEDULE (PFS) FINAL RULE

In the CY 2025 Medicare PFS final rule, CMS introduced HCPCS add-on code +G0561.[1]

Effective January 1, 2025

HCPCS	DESCRIPTION
+G0561	Tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral (list separately in addition to 69433) (do not use in conjunction with 0583T).

Purpose of +G0561

HCPCS code +G0561 was created as an add-on to existing CPT® 69433 to account for the additional practice expenses incurred when performing tympanostomy procedures in a physician's office when tympanostomy tube delivery devices are required. +G0561 accounts for resources and expertise, as well as tube delivery devices and/or systems, that are necessary when performing in-office tympanostomy procedures, and which are not accounted for in the value of code 69433.

Coding Guidelines

CLAIM ADJUDICATION: +G0561 should be reported alongside the primary tympanostomy procedure code (69433) to indicate that the procedure was conducted in an office environment under local anesthesia using a tympanostomy tube delivery device.

PAYER REIMBURSEMENT CONSIDERATIONS:
By appending +G0561 to CPT code 69433, providers can receive additional and adequate compensation reflecting the higher practice expenses and device costs associated with in-office tympanostomy procedures.

CMS introduced +G0561 for tympanostomy procedures in physician office settings as part of its CY 2025 PFS final rule, particularly with pediatric patients in mind.[1] CMS recognized the enhanced safety of the in-office procedure for young patients due to the reduced need for general anesthesia.[2,3,4]

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Provider Considerations for +G0561

Under correct coding principles, providers must report the HCPCS and/or CPT codes that describe the procedure performed to the greatest specificity possible. Accordingly, if a provider is furnishing an in-office tympanostomy procedure using a tympanostomy tube delivery device (such as the Hummingbird TTS from Preceptis Medical) with local or topical anesthesia, then correct coding principles dictate that providers must report CPT code 69433 with HCPCS add-on code +G0561 on claims. This appropriately and precisely identifies the complete procedure. The provider must use +G0561 on claims unless a payer explicitly advises the provider not to use such code (e.g. in circumstances where a payer does not accept G-codes).

As with many new HCPCS codes, positive payer coverage and payment policies are developed over time as payers gain knowledge and experience patient demand through prior authorizations, claim submissions, and appeals. Preceptis Medical is working to help payers understand the Hummingbird technology and its utility for pediatric patients, and has gained positive payment for tympanostomy procedures performed with the Hummingbird device using HCPCS add-on +G0561 from payers in select markets. Billing staff are encouraged to be as informed as possible on the coding, coverage, and payment scenarios for +G0561. Please check with your payers and contractual agreements to determine if specific reimbursement guidance on tympanostomy procedures using the Hummingbird device has been provided.

Frequently Asked Questions (FAQs)

1. **What is a G-code?**
   A G-code is a type of Healthcare Common Procedure Coding System (HCPCS) Level II code used by Medicare and other payers to identify specific professional services or procedures (including devices and practice expenses) not covered by the American Medical Association's Current Procedural Terminology (CPT) codes. G-codes are assigned by CMS to support new procedures (including devices and practice expenses) or to address gaps in CPT code coverage.

2. **Why did CMS establish a G-code vs. a CPT code**
   G-codes exist to cover services or procedures (including devices and practice expenses) that are not yet captured by the CPT system.

3. **How are G-codes used?**
   G-codes are used similarly to CPT codes when submitting claims for Medicare reimbursement. When filing a claim that includes a G-code, providers must remember to:

   CLAIM FORM: Use the CMS-1500 form for professional claims.

   SECTION: Enter the G-code in the "Procedures, Services, or Supplies" field (Item 24D on the CMS-1500 form).

   CLAIM SUBMISSION: Ensure all required supporting documentation is included with the submission (invoices, practice expense coding crosswalks, etc.), because payers may require specific details for reimbursement.

4. **Does a G-code have a value?**
   Not all G-codes have an assigned national payment rate. Some are "contractor-priced," meaning their value is determined by Medicare Administrative Contractors (MACs), commercial payers, or Medicaid plans, rather than by a national CMS-set value. For contractor-priced G-codes, reimbursement rates may vary by region and payer, with MACs and payers setting valuations based on specific local criteria, costs, and utilization data. +G0561 is currently contractor-priced.

5. **How does contractor pricing work for G-codes, and what does it mean for providers and payers?**
   When a G-code is designated as contractor-priced, MACs, commercial payers, and Medicaid plans individually determine the reimbursement rate. This approach results in a decentralized pricing system:

   FOR PROVIDERS: Reimbursement rates for contractor-priced G-codes can vary by region. Payers will consider the local practice costs, patient demographics, and additional procedure-specific resources required, which means that providers may experience different payment levels based on their location. Providers need to understand the +G0561 pricing by coordinating with MACs, commercial payers, and state Medicaid programs to determine reimbursement for specific G-code procedures. Providers may have to collaborate with their provider relations representatives at commercial payers to negotiate a payment rate for the code.

   IMPLICATIONS: Providers and payers alike need to stay informed of rate changes or policy updates from MACs, commercial insurers, and Medicaid plans. Adjusting billing practice according to local claim submission guidance and ensuring clear documentation are key steps for providers to ensure correct reimbursement.

6. **Are providers required to use the G-code?**
   Providers are required to use the add-on G-code +G0561 with the primary tympanostomy procedure CPT code 69433 when using the Hummingbird TTS device in the physician's office. Doing so aligns with **proper coding guidelines** for accurately reporting the costs associated with specific procedures, especially when additional resources are required, as with pediatric tympanostomy procedures in an office setting.

   PROPER CODING GUIDELINES FOR USING THE ADD-ON G-CODE (E.G., +G0561): +G0561 was designed as an add-on code and should be used together with the primary tympanostomy CPT code 69433. The G-code is not intended to stand alone; it enhances the base code by capturing the added practice expenses involved in performing the procedure in-office.

   DOCUMENTATION REQUIREMENTS: Providers should include thorough documentation when billing with an add-on G-code. This includes specifics on the additional equipment (such as the Hummingbird device) and additional staff resources required to manage the procedure effectively in an office environment.

Frequently Asked Questions (FAQs), *continued*

REIMBURSEMENT IMPLICATIONS: Using the G-code accurately reflects the increased costs associated with pediatric cases, helping to ensure more appropriate reimbursement. Not using it may result in undercompensation for in-office tympanostomy on pediatric patients where specialized tools and support staff are essential.

By adhering to these coding guidelines, providers ensure they are compliant and transparent about the resources used for pediatric tympanostomy procedures, thereby improving the likelihood of correct and complete reimbursement.

7. **Can a provider bill the patient if a payer does not cover or pay for the G-code?**
   A provider may be able to bill the patient if the payer does not cover or pay for the G-code. This often depends on the payer's policies and whether the patient has signed an agreement acknowledging financial responsibility for non-covered services. Providers should inform patients in advance if there's a possibility the G-code might not be covered, allowing patients to make informed decisions before proceeding with the service. Some payers may also require patients to sign an Advance Beneficiary Notice (ABN) or similar document to confirm they understand their financial responsibility.

8. **What options does the provider have to determine coverage of the G-code?**
   Providers have several options for determining coverage of the G-code:

   PRIOR AUTHORIZATION TO DETERMINE COVERAGE/ NON-COVERAGE: Providers can request prior authorization from the payer before performing the procedure to confirm if the G-code will be covered. This approach provides upfront clarity on whether the additional costs associated with the G-code will be reimbursed, reducing the likelihood of denial and ensuring patients are informed about any out-of-pocket responsibilities.

   SUBMIT A CLAIM WITH SUPPORTING INFORMATION, AND BILL THE PATIENT IF THE PAYER DENIES THE PROCEDURE AS NON-COVERED: Providers may also choose to submit the claim with all necessary supporting documentation (such as medical necessity or patient condition details) that justify the additional expenses for the procedure. Generally, providers may bill the patient directly if the payer denies coverage or payment for the G-code, as long as the patient has been informed in advance of the potential non-coverage, the patient has agreed to pay for non-covered services, and the provider follows payer guidelines for billing for non-covered services.

   PAYER OUTREACH AND MEDICAL POLICY REVIEW: Providers may proactively reach out to provider relations or contracting contacts to determine whether a payer covers and pays for +G0561 at a network level. Providers may also review payer medical or reimbursement policies to determine if +G0561 is identified in a specific policy.

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4. Truitt MD, Theodore O., et al. "In-office insertion tympanostomy tubes in children using single-pass device" *Laryngoscope Investigative Otolaryngology*. 2021;6:325-331.

DISCLAIMER: The information in this document is for educational purposes only and does not guarantee reimbursement. Billing and coding requirements may vary by payer, and providers are responsible for verifying specific requirements with the relevant insurance or government entities. This document is not intended as legal, regulatory, or financial advice. We recommend consulting with billing specialists or other professionals for compliance.

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