2021 Coding & Payment Quick Reference

Select Bedside Bronchoscopy Procedures

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

The following codes are thought to be relevant to Bedside Bronchoscopy procedures and are referenced throughout this guide.

All rates shown are 2021 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

		2021 Medicare National Average Payment	
		RVUs	Facility[3]
CPT® Code[1]	Code Description	Work	In-Facility
Bronchial Alveolar Lavage, Therapeutic Aspiration, Endobronchial Biopsy and Airway Inspection			
31615	Tracheobronchoscopy through established tracheostomy incision	1.84	$116
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	2.53	$134
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	2.63	$134
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	2.63	$136
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	3.11	$158
31645	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial	2.88	$149
31646	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay	2.78	$144

ICD-10	Description
0B9C8ZX	Drainage of Right Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9C8ZZ	Drainage of Right Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic
0B9D8ZX	Drainage of Right Middle Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9D8ZZ	Drainage of Right Middle Lung Lobe, Via Natural or Artificial Opening Endoscopic
0B9F8ZX	Drainage of Right Lower Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9F8ZZ	Drainage of Right Lower Lung Lobe, Via Natural or Artificial Opening Endoscopic
0B9G8ZX	Drainage of Left Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9G8ZZ	Drainage of Left Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic
0B9H8ZX	Drainage of Lung Lingula, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9H8ZZ	Drainage of Lung Lingula, Via Natural or Artificial Opening Endoscopic
0B9J8ZX	Drainage of Left Lower Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9J8ZZ	Drainage of Left Lower Lung Lobe, Via Natural or Artificial Opening Endoscopic
0B9K8ZX	Drainage of Right Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9K8ZZ	Drainage of Right Lung, Via Natural or Artificial Opening Endoscopic
0B9L8ZX	Drainage of Left Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9L8ZZ	Drainage of Left Lung, Via Natural or Artificial Opening Endoscopic
0B9M8ZX	Drainage of Bilateral Lungs, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9M8ZZ	Drainage of Bilateral Lungs, Via Natural or Artificial Opening Endoscopic
0BB28ZX	Excision of Carina, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB38ZX	Excision of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB48ZX	Excision of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic

See important notes on the uses and limitations of this information on page 3.

Effective: 1JAN2021
Expires: 31DEC2021
MS-DRG Rates Expire: 30SEP2021
ENDO-954603-AA

MS-DRG	Description
0BB58ZX	Excision of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB68ZX	Excision of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB78ZX	Excision of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB88ZX	Excision of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB98ZX	Excision of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBB8ZX	Excision of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD38ZX	Extraction of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD48ZX	Extraction of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD58ZX	Extraction of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD68ZX	Extraction of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD78ZX	Extraction of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BJ08ZZ	Inspection of Tracheobronchial Tree, Via Natural or Artificial Opening Endoscopic
0BJ18ZZ	Inspection of Trachea, Via Natural or Artificial Opening Endoscopic
0BJK8ZZ	Inspection of Right Lung, Via Natural or Artificial Opening Endoscopic
0BJL8ZZ	Inspection of Left Lung, Via Natural or Artificial Opening Endoscopic

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
Non-OR procedures - do not affect the DRG		will vary by DRG

Medicare Physician, Hospital Outpatient, and ASC Payments

		2021 Medicare National Average Payment	
		RVUs	Facility[3]
CPT® Code[1]	Code Description	Work	In-Facility
Percutaneous Tracheostomy			
31600	Tracheostomy, planned (separate procedure);	5.56	$313
31601	Tracheostomy, planned (separate procedure); younger than 2 years	8.00	$455
31603	Tracheostomy, emergency procedure; transtracheal	6.00	$327

ICD-10	Description
0B113F4	Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Approach
0B114F4	Bypass Trachea to Cutaneous with Tracheostomy Device, Percutaneous Endoscopic Approach
0BH14DZ	Insertion of Intraluminal Device into Trachea, Percutaneous Endoscopic Approach

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
003	ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R.	$122,064
004	Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except Face, Mouth and Neck without Major O.R.	$76,242
011	Tracheostomy for Face, Mouth, and Neck Diagnoses or Laryngectomy with MCC	$32,242
012	Tracheostomy for Face, Mouth, and Neck Diagnoses or Laryngectomy with CC	$24,629
013	Tracheostomy for Face, Mouth, and Neck Diagnoses or Laryngectomy without CC/MCC	$17,486
166	Other Respiratory System O.R. Procedures with MCC	$24,358
167	Other Respiratory System O.R. Procedures with CC	$11,961
168	Other Respiratory System O.R. Procedures without CC/MCC	$8,802

See important notes on the uses and limitations of this information on page 3.

C-Code Information

There is no applicable Medicare C-Code for a single use bronchoscope

Revenue Code

Single use bronchoscopes are by definition, single use sterile devices and may be reported using revenue code 278 - Medical/surgical supplies and devices; other implants.

Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.

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† Comprehensive APCs (C-APCs): In 2014, CMS implemented their C-APC policy with the goal of identifying certain high-cost device-related outpatient procedures (formerly "device intensive" APCs). CMS has fully implemented this policy and has identified these high-cost, device-related services as the primary service on a claim. All other services reported on the same date will be considered "adjunctive, supportive, related or dependent services" provided to support the delivery of the primary service and will be unconditionally packaged into the OPPS C-APC payment of the primary service with minor exceptions.

‡ The 2021 National Average Medicare physician payment rates have been calculated using a 2021 conversion factor of $34.8931. Rates subject to change.

NA "NA" indicates that there is no in-office differential for these codes.

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2 Center for Medicare and Medicaid Services. CMS Physician Fee Schedule - December 2020 release, RVU21A file https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f.

3 December 2020 Federal Register CMS-1736-FC https://www.cms.gov/files/document/12220-opps-final-rule-cms-1736-fc.pdf.

4 National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($6,427.41). Source: September 2020 Federal Register.

5 The patient's medical record must support the existence and treatment of the complication or comorbidity.

6 May include but is not limited to one of the following hemostasis techniques: injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator.

SEQUESTRATION DISCLAIMER: Rates referenced in these guides do not reflect Sequestration, automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of March 31, 2021.

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Boston Scientific Corporation
300 Boston Scientific Way
Marlboro, MA 01752
www.bostonscientific.com

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