



2019 Procedural Reimbursement Guide

Airway Endoscopy

THIS PROCEDURAL REIMBURSEMENT GUIDE, FOR SELECT AIRWAY ENDOSCOPY PROCEDURES

, provides coding and reimbursement information for physicians and facilities. The Medicare payment amounts shown are national average payments. Actual reimbursement will vary for each provider and institution based on geographic differences in costs, hospital teaching status, and proportion of low-income patients.

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 Airway Endoscopy procedures and are referenced throughout this guide.

DESCRIPTION OF PAYMENT METHODS

PHYSICIAN BILLING AND PAYMENT: Medicare and most other insurers typically reimburse physicians based on fee schedules tied to **CPT® CODES**. CPT Codes are published by the American Medical Association and are used to report medical services and procedures performed by or under the direction of physicians.

HOSPITAL OUTPATIENT BILLING AND PAYMENT: Medicare reimburses hospitals for outpatient stays (typically stays of less than 24 hours) under **AMBULATORY PAYMENT CLASSIFICATION GROUPS (APCs)**. Medicare assigns a procedure to an APC based on the billed CPT Code. Hospitals may receive separate APC payments for each procedure done during the same outpatient visit. Many APCs are subject to reduced payment when multiple procedures are performed on the same day. In most cases, the highest valued procedure is paid at 100% and all other procedures are subject to a 50% payment reduction.

In 2014, CMS implemented their **COMPREHENSIVE APCs (C-APCs)** 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 OPSS C-APC payment of the primary service with minor exceptions. Only select airway endoscopy APCs are impacted. Procedures that are impacted are flagged (†) throughout the guide.

HOSPITAL INPATIENT BILLING AND PAYMENT: Medicare reimburses hospital inpatient procedures based on the **MEDICARE SEVERITY DIAGNOSIS RELATED GROUP (MS-DRG)**. The MS-DRG is a system of classifying patients based on their diagnoses and the procedures performed during their hospital stay. MS-DRGs closely calibrate payment to the severity of a patient’s illness. One single MS-DRG payment is intended to cover all hospital costs associated with treating an individual during his or her hospital stay, with the exception of “professional” (e.g., physician charges associated with performing medical procedures). Private payers may also use MS-DRG based systems or other payer-specific systems to pay hospitals for providing inpatient services. Effective October 1, 2013, Medicare implemented two-midnight stay guidance. Inpatient admittance is presumed to be appropriate if a physician expects a beneficiary’s surgical procedure, diagnostic test or other treatment to require a stay in the hospital lasting at least two midnights, and admits the beneficiary to the hospital based on that expectation. Documentation in the medical record must support a reasonable expectation of the need for the beneficiary to require a medically necessary stay lasting at least two midnights. If the inpatient admission lasts fewer than two midnights due to an unforeseen circumstance this also must be clearly documented in the medical record.

FREE-STANDING CLINIC/AMBULATORY SURGICAL CENTER BILLING AND PAYMENT: Many procedures are performed outside of the hospital in free-standing clinics. Payments made to free-standing clinics from private insurers depend on the contract the clinic has with the payer. Medicare payments to free-standing clinics are determined in part, by the licensing status of the clinic. If a free-standing clinic is licensed by Medicare as an **AMBULATORY SURGICAL CENTER (ASC)** it is eligible to be reimbursed for select procedures provided in this setting. Not all procedures that Medicare covers in the hospital setting are eligible for payment in ASCs. Medicare has approved over 3,900 procedures (as defined by CPT Code), for which it will pay the ASC a facility fee.

THIS GUIDE, FOR SELECT AIRWAY ENDOSCOPY PROCEDURES, PROVIDES CODING AND REIMBURSEMENT INFORMATION FOR PHYSICIANS AND FACILITIES.

THE CODES INCLUDED IN THIS GUIDE ARE INTENDED TO REPRESENT TYPICAL AIRWAY ENDOSCOPY PROCEDURES WHERE THERE IS:

- 1) At least one device approved or cleared by the U.S. Food and Drug Administration (FDA) for use in the listed procedure; and
- 2) Specific procedural coding guidance provided by a recognized coding or reimbursement authority such as the American Medical Association (AMA) or The Centers for Medicare and Medicaid Services (CMS). This guide is in no way intended to promote the off label use of medical devices.

THE MEDICARE REIMBURSEMENT AMOUNTS SHOWN ARE CURRENTLY PUBLISHED NATIONAL AVERAGE PAYMENTS.

Actual reimbursement will vary for each provider and institution for a variety of reasons including geographic difference in labor and non-labor costs, hospital teaching status, and/or proportion of low-income patients. On average, private payers pay more than Medicare.⁷

Please feel free to contact the Boston Scientific Endoscopy Reimbursement Help Desk at 508.683.4510 or at ENDOREIMBURSEMENT@bsci.com if you have any questions.

You can find reimbursement updates on our website: WWW.BOSTONSCIENTIFIC.COM/REIMBURSEMENT

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.

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered. It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label. Information included herein is current as of November 2018 but is subject to change without notice. Rates for services are effective January 1, 2019.

Airway Endoscopy Procedural Reimbursement Guide

All rates shown are 2019 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

2019 Medicare National Average Payment

CPT® Code ¹	Code Description	RVUs			Physician ²		Facility ³	
		Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Balloon Dilatation								
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilatation or closed reduction of fracture	3.81	NA	5.71	NA	\$206	\$2,741 ¹	\$1,181
Biopsy (with Forceps)								
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	3.11	9.59	4.49	\$346	\$162	\$1,369 ¹	\$604
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	3.55	10.18	5.06	\$367	\$182	\$2,741 ¹	\$1,181
31632	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (List separately in addition to code for primary procedure)*	1.03	1.81	1.41	\$65	\$51	\$0	\$0
Bronchial Thermoplasty								
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	4.00	NA	5.62	NA	\$203	\$5,148 ¹	N/A*
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	4.25	NA	5.93	NA	\$214	\$5,148 ¹	N/A*
Cytology and Brushing								
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	2.53	6.84	3.78	\$247	\$136	\$1,369 ¹	\$604
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	2.63	7.51	3.81	\$271	\$137	\$1,369 ¹	\$604
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	2.63	7.10	3.86	\$256	\$139	\$1,369 ¹	\$604
Endobronchial Ultrasound (EBUS) Guided Needle Aspiration Biopsy								
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	4.46	27.42	6.39	\$988	\$230	\$2,741 ¹	\$1,181
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	4.96	28.73	7.08	\$1,035	\$255	\$2,741 ¹	\$1,181
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s)	1.40	3.53	1.94	\$127	\$70	\$0	\$0
Foreign Body Removal (Stent Removal)								
31635	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of foreign body	3.42	8.03	5.06	\$289	\$182	\$1,369 ¹	\$604
Needle Aspiration Biopsy (TBNA)								
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	3.75	12.59	5.38	\$454	\$194	\$2,741 ¹	\$1,181
31633	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (List separately in addition to code for primary procedure)*	1.32	2.27	1.83	\$82	\$66	\$0	\$0
31645	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess with therapeutic aspiration of tracheobronchial tree, initial)	2.88	7.42	4.21	\$267	\$152	\$1,369 ¹	\$604
Stenting								
31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilatation as required)	4.36	NA	6.58	NA	\$237	\$5,148 ¹	\$1,791
31636	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilatation as required), initial bronchus	4.30	NA	6.35	NA	\$229	\$5,148 ¹	\$2,564
31637	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; each additional major bronchus stented (List separately in addition to code for primary procedure)*	1.58	NA	2.22	NA	\$80	\$0	\$0
31638	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with revision of tracheal or bronchial stent inserted at previous session (includes tracheal/bronchial dilatation as required)	4.88	NA	7.21	NA	\$260	\$5,148 ¹	\$1,791

Please refer to page 10 for footnotes

See important information about the uses and limitations of this document on pages 2 and 3

Medicare Hospital Outpatient Facility Payment

APC	Description	2019 Medicare National Average Payment ³
5153	Level 3 Airway Endoscopy	\$1,369 [†]
5154	Level 4 Airway Endoscopy	\$2,741 [†]
5155	Level 5 Airway Endoscopy	\$5,148 [†]

Endoscopy C-Code Summary

To determine whether there are relevant C-codes for any Boston Scientific products, please visit our C-code finder at <http://www.bostonscientific.com/en-US/reimbursement/ccode-finder.html>.

C-Codes are tracking codes established by the Centers for Medicare & Medicaid Services (CMS) to assist Medicare in establishing future APC payment rates. C-Codes only apply to Medicare hospital outpatient claims. They do not trigger additional payment to the facility today.

It is very important that hospitals report C-Codes as well as the associated device costs. This will help inform and potentially increase future outpatient hospital payment rates.

C-Code	C-Code Description	Devices Impacted ¹
C1726	Catheter, balloon dilation, non-vascular	CRE Single-Use Pulmonary Balloon Dilators
C1769	Guide wire	All BSC guidewires used in GI procedures: Dreamwire™ Guidewire, Hydra Jagwire™ Guidewire, Jagwire™ Guidewire, Pathfinder™ Guidewire
C1874	Stent, coated/covered, with delivery system	Ultraflex Single-Use Covered Tracheobronchial Stent System – Distal Release
C1875	Stent, coated/covered without delivery system	Dynamic™ (Y) Stent
C1876	Stent, non-coated/non-covered, with delivery system	Ultraflex Single-Use Uncovered Tracheobronchial Stent System – Distal Release
		Ultraflex Single-Use Uncovered Tracheobronchial Stent System – Proximal Release
C1886	Catheter, extravascular tissue ablation, any modality (insertable)	Alair™ Bronchial Thermoplasty Catheter

C-Code Reference Tool

For all C-Code information, please reference the C-code Finder: www.bostonscientific.com/reimbursement

[†] 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 OPSS C-APC payment of the primary service with minor exceptions.

* Note: There is a separate facility and physician payment for outpatient hospital services. The values in this table refer to the outpatient hospital facility payment only.

Medicare Hospital Inpatient Coding

ICD-10 PCS procedure codes are used by the hospital inpatient department to report the medical and/or surgical procedure performed on a patient.

ICD-10 PCS Code	ICD-10 PCS Description
07B74ZX	Excision of Thorax Lymphatic, Percutaneous Endoscopic Approach, Diagnostic
07D74ZX	Extraction of Thorax Lymphatic, Percutaneous Endoscopic Approach, Diagnostic
07D84ZX	Extraction of Right Internal Mammary Lymphatic, Percutaneous Endoscopic Approach, Diagnostic
07D94ZX	Extraction of Left Internal Mammary Lymphatic, Percutaneous Endoscopic Approach, Diagnostic
07DK4ZX	Extraction of Thoracic Duct, Percutaneous Endoscopic Approach, Diagnostic
0B538ZZ	Destruction of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic
0B548ZZ	Destruction of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B558ZZ	Destruction of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B568ZZ	Destruction of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B578ZZ	Destruction of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic
0B588ZZ	Destruction of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B598ZZ	Destruction of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic
0B5B8ZZ	Destruction of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B718DZ	Dilation of Trachea with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B718ZZ	Dilation of Trachea, Via Natural or Artificial Opening Endoscopic
0B728DZ	Dilation of Carina with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B728ZZ	Dilation of Carina, Via Natural or Artificial Opening Endoscopic
0B738DZ	Dilation of Right Main Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B738ZZ	Dilation of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic
0B748DZ	Dilation of Right Upper Lobe Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B748ZZ	Dilation of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B758DZ	Dilation of Right Middle Lobe Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B758ZZ	Dilation of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B768DZ	Dilation of Right Lower Lobe Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B768ZZ	Dilation of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B778DZ	Dilation of Left Main Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B778ZZ	Dilation of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic
0B788DZ	Dilation of Left Upper Lobe Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B788ZZ	Dilation of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B798DZ	Dilation of Lingula Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B798ZZ	Dilation of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic
0B7B8DZ	Dilation of Left Lower Lobe Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B7B8ZZ	Dilation of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
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

Medicare Hospital Inpatient Coding (Continued)

ICD-10 PCS Code	ICD-10 PCS Description
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
0BB18ZX	Excision of Trachea, Via Natural or Artificial Opening Endoscopic, Diagnostic
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
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
0BBC8ZX	Excision of Right Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBD8ZX	Excision of Right Middle Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBF8ZX	Excision of Right Lower Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBG8ZX	Excision of Left Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBJ8ZX	Excision of Left Lower Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBK8ZX	Excision of Right Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBL8ZX	Excision of Left Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBM8ZX	Excision of Bilateral Lungs, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BC18ZZ	Extirpation of Matter from Trachea, Via Natural or Artificial Opening Endoscopic
0BC28ZZ	Extirpation of Matter from Carina, Via Natural or Artificial Opening Endoscopic
0BC38ZZ	Extirpation of Matter from Right Main Bronchus, Via Natural or Artificial Opening Endoscopic
0BC48ZZ	Extirpation of Matter from Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BC58ZZ	Extirpation of Matter from Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BC68ZZ	Extirpation of Matter from Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BC78ZZ	Extirpation of Matter from Left Main Bronchus, Via Natural or Artificial Opening Endoscopic
0BC88ZZ	Extirpation of Matter from Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BC98ZZ	Extirpation of Matter from Lingula Bronchus, Via Natural or Artificial Opening Endoscopic
0BCB8ZZ	Extirpation of Matter from Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BD18ZX	Extraction of Trachea, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD24ZX	Extraction of Carina, Percutaneous Endoscopic Approach, Diagnostic
0BD28ZX	Extraction of Carina, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD34ZX	Extraction of Right Main Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BD38ZX	Extraction of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD44ZX	Extraction of Right Upper Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BD48ZX	Extraction of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD54ZX	Extraction of Right Middle Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BD58ZX	Extraction of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD64ZX	Extraction of Right Lower Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic

Please refer to page 10 for footnotes

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Medicare Hospital Inpatient Coding (Continued)

ICD-10 PCS Code	ICD-10 PCS Description
0BD68ZX	Extraction of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD74ZX	Extraction of Left Main Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BD78ZX	Extraction of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD84ZX	Extraction of Left Upper Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BD88ZX	Extraction of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD94ZX	Extraction of Lingula Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BD98ZX	Extraction of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDB4ZX	Extraction of Left Lower Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BDB8ZX	Extraction of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDC4ZX	Extraction of Right Upper Lung Lobe, Percutaneous Endoscopic Approach, Diagnostic
0BDC8ZX	Extraction of Right Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDD4ZX	Extraction of Right Middle Lung Lobe, Percutaneous Endoscopic Approach, Diagnostic
0BDD8ZX	Extraction of Right Middle Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDF4ZX	Extraction of Right Lower Lung Lobe, Percutaneous Endoscopic Approach, Diagnostic
0BDF8ZX	Extraction of Right Lower Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDG4ZX	Extraction of Left Upper Lung Lobe, Percutaneous Endoscopic Approach, Diagnostic
0BDG8ZX	Extraction of Left Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDH4ZX	Extraction of Lung Lingula, Percutaneous Endoscopic Approach, Diagnostic
0BDH8ZX	Extraction of Lung Lingula, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDJ4ZX	Extraction of Left Lower Lung Lobe, Percutaneous Endoscopic Approach, Diagnostic
0BDJ8ZX	Extraction of Left Lower Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDK4ZX	Extraction of Right Lung, Percutaneous Endoscopic Approach, Diagnostic
0BDK8ZX	Extraction of Right Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDL4ZX	Extraction of Left Lung, Percutaneous Endoscopic Approach, Diagnostic
0BDL8ZX	Extraction of Left Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDM4ZX	Extraction of Bilateral Lungs, Percutaneous Endoscopic Approach, Diagnostic
0BDM8ZX	Extraction of Bilateral Lungs, 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
0BW08DZ	Revision of Intraluminal Device in Tracheobronchial Tree, Via Natural or Artificial Opening Endoscopic
0BW18DZ	Revision of Intraluminal Device in Trachea, Via Natural or Artificial Opening Endoscopic

Medicare Hospital Inpatient Payment

Rates Effective October 1, 2018 - September 30, 2019

MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment [†]
163	Major Chest Procedures with MCC ^{5,7}	\$30,035
164	Major Chest Procedures with CC ⁵	\$15,684
165	Major Chest Procedures without CC/MCC	\$11,310
166	Other Respiratory System O.R. Procedures with MCC	\$21,357
167	Other Respiratory System O.R. Procedures with CC	\$11,586
168	Other Respiratory System O.R. Procedures without CC/MCC	\$8,191

Footnotes

- † 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 OPSS C-APC payment of the primary service with minor exceptions.
- ‡ The 2019 National Average Medicare physician payment rates have been calculated using a 2019 conversion factor of \$36.0391. Rates subject to change.
- NA “NA” indicates that there is no in-office differential for these codes.
- N/A* Medicare has not developed a rate for the ASC setting as the procedure is typically performed in the hospital setting.
- 1 Current Procedural Terminology (CPT) copyright 2018 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
- 2 Center for Medicare and Medicaid Services. CMS Physician Fee Schedule - November 2018 release, RVU17A file <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>
- 3 Source: November 2, 2018 Federal Register CMS-1695-F December 28, 2018 Federal Register CMS-1695-CN2.
- 4 National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$6,105.49). Source: September 21, 2018 Federal Register.
- 5 The patient’s medical record must support the existence and treatment of the complication or comorbidity
- 6 Likely to pertain to bronchial thermoplasty only.
- 7 Based on estimate that non-Medicare payment for outpatient hospital services is 1.8 times Medicare payment. Source: High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power by Chapin White, Amelia M. Bond and James D. Reschovsky.

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 January 1, 2019.

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