

### 2009 CODING & PAYMENT QUICK REFERENCE

#### MEDICARE PHYSICIAN, HOSPITAL OUTPATIENT and ASC PAYMENTS

- The bronchoscopy procedures listed below (except 31622) all include a diagnostic bronchoscopy when performed by the same physician.

CPT® Code <sup>1</sup>	Code Description	Physician <sup>2</sup>		Facility <sup>3</sup>	
		MD Payment In-office	MD Payment In-facility	Hospital Outpatient Payment	ASC Payment
<b>Biopsy Forcep</b>					
31625	Bronchoscopy; with biopsy(s)	\$325	\$167	\$674	\$423
31628	Bronchoscopy; with transbronchial lung biopsy, single lobe	\$390	\$186	\$674	\$423
31632	Bronchoscopy, (rigid or flexible); with transbronchial lung biopsy, each additional lobe (report separately in addition to code for primary procedure)	\$74	\$53	\$337 <sup>4</sup>	\$206 <sup>4</sup>
<b>Cytology and Brush</b>					
31622	Bronchoscopy; diagnostic, with or without cell washing	\$296	\$141	\$674	\$368
31623	Bronchoscopy; with brushing	\$323	\$142	\$674	\$423
31624	Bronchoscopy; with bronchial alveolar lavage	\$301	\$143	\$674	\$423
<b>Stenting</b>					
31631	Bronchoscopy; with tracheal dilation and placement of tracheal stent	NA*	\$225	\$1,662	\$725
31636	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, initial bronchus	NA*	\$220	\$1,662	\$725
31637	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, each additional major bronchus (report separately in addition to code for primary procedure)	NA*	\$78	\$337 <sup>4</sup>	\$184 <sup>4</sup>
31638	Bronchoscopy; with tracheal/bronchial dilation and revision of tracheal or bronchial stent inserted at previous session	NA*	\$245	\$1,662	\$725
<b>Foreign Body Removal (Stent Removal)</b>					
31635	Bronchoscopy; with removal of foreign body	\$334	\$185	\$674	\$423
<b>Needle Aspiration</b>					
31629	Bronchoscopy; with transbronchial needle aspiration biopsy, trachea, main stem and/or lobar bronchus	\$595	\$198	\$674	\$423
31633	Bronchoscopy, (rigid or flexible); with transbronchial needle aspiration biopsy, each additional lobe (report separately in addition to code for primary procedure)	\$88	\$66	\$337	\$184
31645	Bronchoscopy; with therapeutic aspiration of tracheobronchial tree (e.g., drainage of lung abscess)	\$291	\$157	\$674	\$368

\* NA = Medicare has not developed a rate for the In-Office setting as the procedure is typically performed in the hospital setting. If the contractor determines the service can be performed in-office, it will be paid at the MD In-facility rate.

<sup>1</sup>Source: Beebe et al. (2008). *CPT®2009 Professional Edition*. Chicago: American Medical Association. CPT® is a registered trademark of American Medical Association. All Rights Reserved.

<sup>2</sup>Source: November 19, 2008 Federal Register. MD payments calculated using the 2009 conversion factor of \$36.066.

<sup>3</sup>Source: November 18, 2008 Federal Register.

<sup>4</sup>Represents 50% of full facility payment. Add-on codes are always listed in addition to the primary procedure code and therefore are subject to multiple procedure discounting.

**Important - Please Note:** Reimbursement information provided by Boston Scientific Corporation (BSC) is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice, and BSC makes no representation or warranty regarding this information or its completeness, accuracy or timeliness. Laws, regulations and payer policies concerning reimbursement are complex and change frequently, and service providers are responsible for all decisions relating to coding and reimbursement submissions. Accordingly, BSC strongly recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.

### 2009 CODING & PAYMENT QUICK REFERENCE

#### MEDICARE PHYSICIAN, HOSPITAL OUTPATIENT and ASC PAYMENTS (cont'd)

CPT® Code <sup>1</sup>	Code Description	Physician <sup>2</sup>		Facility <sup>3</sup>	
		MD Payment In-office	MD Payment In-facility	Hospital Outpatient Payment	ASC Facility Payment
<b>Balloon Dilation</b>					
31630	Bronchoscopy; with tracheal or bronchial dilation or closed reduction of fracture	NA*	\$200	\$1,662	\$725
31631	Bronchoscopy; with tracheal dilation and placement of tracheal stent	NA*	\$225	\$1,662	\$725
31636	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, initial bronchus	NA*	\$220	\$1,662	\$725
31637	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, each additional major bronchus (report separately in addition to code for primary procedure)	NA*	\$78	\$337	\$184
31638	Bronchoscopy; with tracheal/bronchial dilation and revision of tracheal or bronchial stent inserted at previous session	NA*	\$245	\$1,662	\$725

\* NA = Medicare has not developed a rate for the In-Office setting as the procedure is typically performed in the hospital setting. If the contractor determines the service can be performed in-office, it will be paid at the MD In-facility rate.

<sup>1</sup>Source: Beebe et al. (2008). *CPT®2009 Professional Edition*. Chicago: American Medical Association. CPT® is a registered trademark of American Medical Association. All Rights Reserved.

<sup>2</sup>Source: November 19, 2008 Federal Register. MD payments calculated using the 2009 conversion factor of \$36.066.

<sup>3</sup>Source: November 18, 2008 Federal Register.

<sup>4</sup>Represents 50% of full facility payment. Add-on codes are always listed in addition to the primary procedure code and therefore are subject to multiple procedure discounting.

**Important - Please Note:** Reimbursement information provided by Boston Scientific Corporation (BSC) is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice, and BSC makes no representation or warranty regarding this information or its completeness, accuracy or timeliness. Laws, regulations and payer policies concerning reimbursement are complex and change frequently, and service providers are responsible for all decisions relating to coding and reimbursement submissions. Accordingly, BSC strongly recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.

### 2009 CODING & PAYMENT QUICK REFERENCE

#### MEDICARE HOSPITAL INPATIENT CODING AND PAYMENT *(Rates Effective October 1, 2007- September 30, 2008)*

ICD-9-CM procedure codes are used by the hospital inpatient department to report the medical and/or surgical procedure performed on a patient.

ICD-9-CM Procedure Code	Description
32.01	Endoscopic excision or destruction of lesion or tissue of bronchus
33.23	Other bronchoscopy
33.24	Closed endoscopic biopsy of bronchus; bronchoscopy (fiber-optic) with brush biopsy of "lung", brushing or washing for specimen collection, excision (bite) biopsy
33.27	Closed endoscopic biopsy of lung; Fiber-optic bronchoscopy with fluoroscopic guidance with biopsy, transbronchial lung biopsy
31.93	Replacement of laryngeal or tracheal stent
31.99	Other operations on trachea
98.15	Removal of intraluminal foreign body from trachea and bronchus without incision

- Effective October 1, 2007, the Center for Medicare and Medicaid Services (CMS) is replacing the Diagnosis Related Groups (DRG) System with the Medicare Severity DRG (MS-DRG) classification system to recognize severity of illness among patients. The new system, which will be phased in over a two-year period, expands the current list of 538 DRGs to a new list of 745 "severity-adjusted" DRGs.
- MS-DRGs resulting from inpatient pulmonary procedures may include (but are not limited to):

MS-DRG	Description	Hospital Inpatient Payment <sup>5</sup>
180	Respiratory neoplasms with Major Complication or Comorbidity (MCC <sup>5</sup> )	\$9,412
181	Respiratory neoplasms pancreas with Complication or Comorbidity (CC <sup>5</sup> )	\$6,839
182	Respiratory neoplasms without CC/MCC	\$4,851
189	Pulmonary edema & respiratory failure	\$7,489
193	Simple pneumonia & pleurisy with MCC <sup>5</sup>	\$7,955
194	Simple pneumonia & pleurisy with CC <sup>5</sup>	\$5,584
195	Simple pneumonia & pleurisy without CC/MCC	\$4,062
196	Interstitial lung disease with MCC <sup>5</sup>	\$8,896
197	Interstitial lung disease with CC <sup>5</sup>	\$6,103
198	Interstitial lung disease without CC/MCC	\$4,552
204	Respiratory signs & symptoms	\$3,636
205	Other respiratory system diagnoses with MCC <sup>5</sup>	\$6,865
206	Other respiratory system diagnoses without CC/MCC	\$4,047

<sup>4</sup>National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5,552.58). Source: October 3, 2008 Federal Register.

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

**Important - Please Note:** Reimbursement information provided by Boston Scientific Corporation (BSC) is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice, and BSC makes no representation or warranty regarding this information or its completeness, accuracy or timeliness. Laws, regulations and payer policies concerning reimbursement are complex and change frequently, and service providers are responsible for all decisions relating to coding and reimbursement submissions. Accordingly, BSC strongly recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.