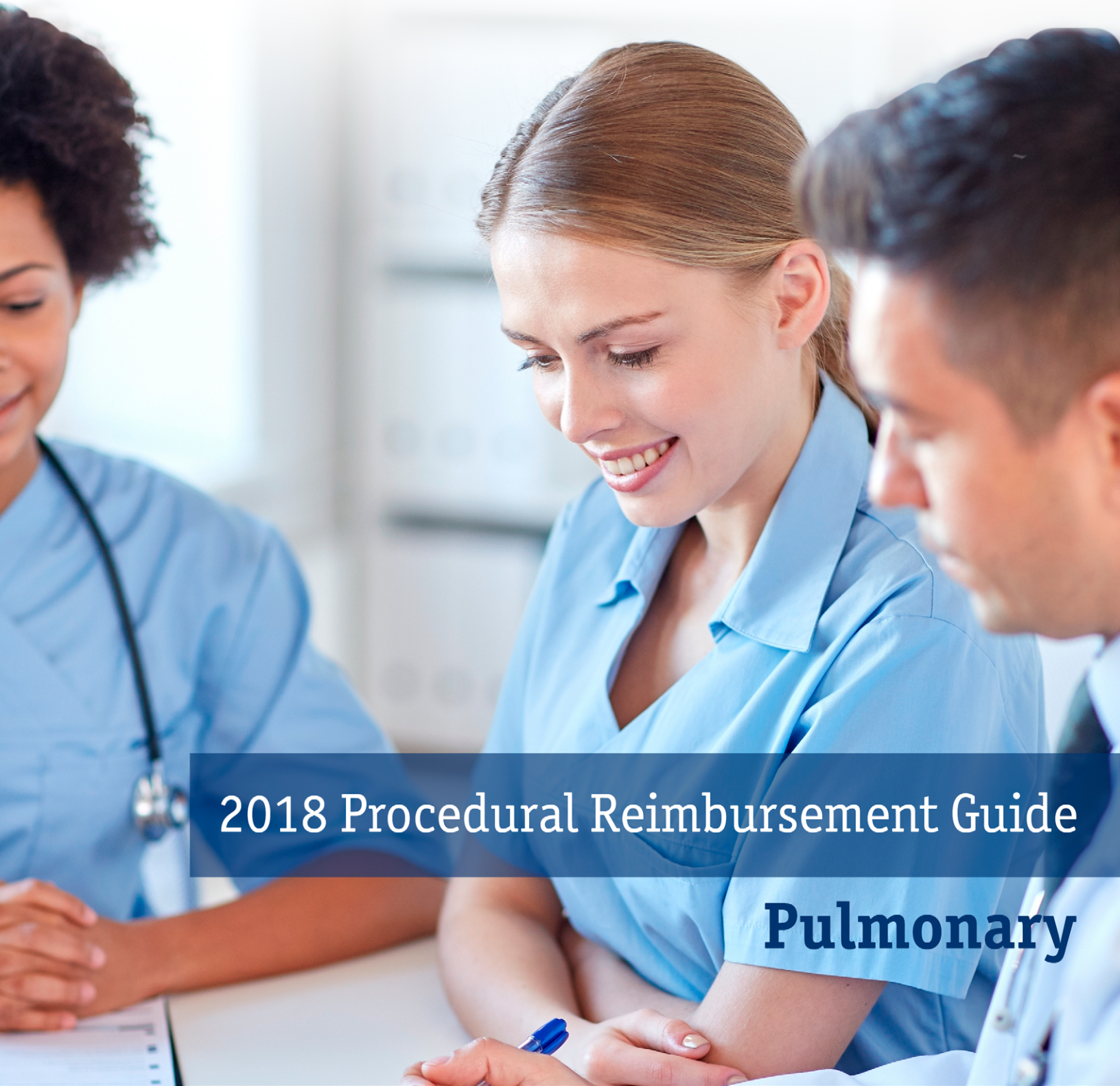
GUIDEPOINT
Reimbursement Resources

Boston Scientific
Advancing science for life™



2018 Procedural Reimbursement Guide

Pulmonary

THIS PROCEDURAL REIMBURSEMENT GUIDE, FOR SELECT PULMONARY 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.

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 OPPS C-APC payment of the primary service with minor exceptions. Only select pulmonary 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 PULMONARY PROCEDURES, PROVIDES CODING AND REIMBURSEMENT INFORMATION FOR PHYSICIANS AND FACILITIES.

THE CODES INCLUDED IN THIS GUIDE ARE INTENDED TO REPRESENT TYPICAL PULMONARY 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

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 that are 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.

Pulmonary Procedural Reimbursement Guide

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 Medicare National Average Payment			
					Physician[‡,2]		Facility[3]	
CPT® Code[1]	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Balloon Dilation								
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	3.81	NA	5.75	NA	$207	$2,617†	$1,148
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	9.45	4.51	$340	$162	$1,324†	$588
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	3.55	10.05	5.09	$362	$183	$2,617†	$1,148
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	1.82	1.42	$66	$51	$0	$0
Bronchial Thermoplasty								
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	4.00	NA	5.63	NA	$203	$4,864†	N/A*
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	4.25	NA	5.96	NA	$215	$4,864†	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	6.86	3.79	$247	$136	$1,324†	$588
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	2.63	7.75	3.86	$279	$139	$1,324†	$588
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	2.63	7.23	3.91	$260	$141	$1,324†	$588
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	23.63	6.40	$851	$230	$2,617†	$1,148
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	24.98	7.10	$899	$256	$2,617†	$1,148
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	3.58	1.95	$129	$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	8.00	5.06	$288	$182	$1,324†	$588
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	12.39	5.39	$446	$194	$2,617†	$1,148
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	2.29	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	7.38	4.23	$266	$152	$1,324†	$588
Stenting								
31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	4.36	NA	6.59	NA	$237	$4,864†	$1,768
31636	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of bronchial stent(s) (includes tracheal/bronchial dilation as required), initial bronchus	4.30	NA	6.38	NA	$230	$4,864†	$2,501
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	2.14	NA	$77	$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 dilation as required)	4.88	NA	7.21	NA	$260	$4,864†	$1,768

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	2018 Medicare National Average Payment[3]
5153	Level 3 Airway Endoscopy	$1,324†
5154	Level 4 Airway Endoscopy	$2,617†
5155	Level 5 Airway Endoscopy	$4,864†

Endoscopy C-Code Summary

C-Code	C-Code Description	Devices Impacted[1]
C1726	Catheter, balloon dilation, non-vascular	CRE Single-Use Pulmonary Balloon Dilators
C1769	Guide wire	Amplatz™ Guidewire
		Jagwire™ Guidewire
C1874	Stent, coated/covered, with delivery system	Ultraflex Single-Use Covered Tracheobronchial Stent System – Distal Release
		Polyflex™ Single-Use Self-Expanding Silicone Airway Stent System
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 OPPS 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
0B534ZZ	Destruction of Right Main Bronchus, Percutaneous Endoscopic Approach
0B538ZZ	Destruction of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic
0B544ZZ	Destruction of Right Upper Lobe Bronchus, Percutaneous Endoscopic Approach
0B548ZZ	Destruction of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B554ZZ	Destruction of Right Middle Lobe Bronchus, Percutaneous Endoscopic Approach
0B558ZZ	Destruction of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B564ZZ	Destruction of Right Lower Lobe Bronchus, Percutaneous Endoscopic Approach
0B568ZZ	Destruction of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B574ZZ	Destruction of Left Main Bronchus, Percutaneous Endoscopic Approach
0B578ZZ	Destruction of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic
0B584ZZ	Destruction of Left Upper Lobe Bronchus, Percutaneous Endoscopic Approach
0B588ZZ	Destruction of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0B594ZZ	Destruction of Lingula Bronchus, Percutaneous Endoscopic Approach
0B598ZZ	Destruction of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic
0B5B4ZZ	Destruction of Left Lower Lobe Bronchus, Percutaneous Endoscopic Approach
0B5B8ZZ	Destruction of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BB34ZZ	Excision of Right Main Bronchus, Percutaneous Endoscopic Approach
0BB38ZZ	Excision of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic
0BB44ZZ	Excision of Right Upper Lobe Bronchus, Percutaneous Endoscopic Approach
0BB48ZZ	Excision of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BB54ZZ	Excision of Right Middle Lobe Bronchus, Percutaneous Endoscopic Approach
0BB58ZZ	Excision of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BB64ZZ	Excision of Right Lower Lobe Bronchus, Percutaneous Endoscopic Approach
0BB68ZZ	Excision of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BB74ZZ	Excision of Left Main Bronchus, Percutaneous Endoscopic Approach
0BB78ZZ	Excision of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic
0BB84ZZ	Excision of Left Upper Lobe Bronchus, Percutaneous Endoscopic Approach
0BB88ZZ	Excision of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
0BB94ZZ	Excision of Lingula Bronchus, Percutaneous Endoscopic Approach
0BB98ZZ	Excision of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic
0BBB4ZZ	Excision of Left Lower Lobe Bronchus, Percutaneous Endoscopic Approach
0BBB8ZZ	Excision of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic
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
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
0BJ08ZZ	Inspection of Tracheobronchial Tree, 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
0B933ZX	Drainage of Right Main Bronchus, Percutaneous Approach, Diagnostic

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 Inpatient Coding (Continued)

ICD-10 PCS Code	ICD-10 PCS Description
0B934ZX	Drainage of Right Main Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0B937ZX	Drainage of Right Main Bronchus, Via Natural or Artificial Opening, Diagnostic
0B938ZX	Drainage of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B943ZX	Drainage of Right Upper Lobe Bronchus, Percutaneous Approach, Diagnostic
0B944ZX	Drainage of Right Upper Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0B947ZX	Drainage of Right Upper Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic
0B948ZX	Drainage of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B953ZX	Drainage of Right Middle Lobe Bronchus, Percutaneous Approach, Diagnostic
0B954ZX	Drainage of Right Middle Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0B957ZX	Drainage of Right Middle Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic
0B958ZX	Drainage of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B963ZX	Drainage of Right Lower Lobe Bronchus, Percutaneous Approach, Diagnostic
0B964ZX	Drainage of Right Lower Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0B967ZX	Drainage of Right Lower Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic
0B968ZX	Drainage of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B973ZX	Drainage of Left Main Bronchus, Percutaneous Approach, Diagnostic
0B974ZX	Drainage of Left Main Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0B977ZX	Drainage of Left Main Bronchus, Via Natural or Artificial Opening, Diagnostic
0B978ZX	Drainage of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B983ZX	Drainage of Left Upper Lobe Bronchus, Percutaneous Approach, Diagnostic
0B984ZX	Drainage of Left Upper Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0B987ZX	Drainage of Left Upper Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic
0B988ZX	Drainage of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B993ZX	Drainage of Lingula Bronchus, Percutaneous Approach, Diagnostic
0B994ZX	Drainage of Lingula Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0B997ZX	Drainage of Lingula Bronchus, Via Natural or Artificial Opening, Diagnostic
0B998ZX	Drainage of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9B3ZX	Drainage of Left Lower Lobe Bronchus, Percutaneous Approach, Diagnostic
0B9B4ZX	Drainage of Left Lower Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0B9B7ZX	Drainage of Left Lower Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic
0B9B8ZX	Drainage of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB33ZX	Excision of Right Main Bronchus, Percutaneous Approach, Diagnostic
0BB34ZX	Excision of Right Main Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BB37ZX	Excision of Right Main Bronchus, Via Natural or Artificial Opening, Diagnostic
0BB38ZX	Excision of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB43ZX	Excision of Right Upper Lobe Bronchus, Percutaneous Approach, Diagnostic
0BB44ZX	Excision of Right Upper Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BB47ZX	Excision of Right Upper Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic
0BB48ZX	Excision of Right Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB53ZX	Excision of Right Middle Lobe Bronchus, Percutaneous Approach, Diagnostic
0BB54ZX	Excision of Right Middle Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BB57ZX	Excision of Right Middle Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic
0BB58ZX	Excision of Right Middle Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB63ZX	Excision of Right Lower Lobe Bronchus, Percutaneous Approach, Diagnostic
0BB64ZX	Excision of Right Lower Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BB67ZX	Excision of Right Lower Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic

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 Inpatient Coding (Continued)

ICD-10 PCS Code	ICD-10 PCS Description
0BB68ZX	Excision of Right Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB73ZX	Excision of Left Main Bronchus, Percutaneous Approach, Diagnostic
0BB74ZX	Excision of Left Main Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BB77ZX	Excision of Left Main Bronchus, Via Natural or Artificial Opening, Diagnostic
0BB78ZX	Excision of Left Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB83ZX	Excision of Left Upper Lobe Bronchus, Percutaneous Approach, Diagnostic
0BB84ZX	Excision of Left Upper Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BB87ZX	Excision of Left Upper Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic
0BB88ZX	Excision of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB93ZX	Excision of Lingula Bronchus, Percutaneous Approach, Diagnostic
0BB94ZX	Excision of Lingula Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BB97ZX	Excision of Lingula Bronchus, Via Natural or Artificial Opening, Diagnostic
0BB98ZX	Excision of Lingula Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBB3ZX	Excision of Left Lower Lobe Bronchus, Percutaneous Approach, Diagnostic
0BBB4ZX	Excision of Left Lower Lobe Bronchus, Percutaneous Endoscopic Approach, Diagnostic
0BBB7ZX	Excision of Left Lower Lobe Bronchus, Via Natural or Artificial Opening, Diagnostic
0BBB8ZX	Excision of Left Lower Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9K8ZX	Drainage of Right Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9L8ZX	Drainage of Left Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B9M8ZX	Drainage of Bilateral Lungs, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBK7ZX	Excision of Right Lung, Via Natural or Artificial Opening, Diagnostic
0BBK8ZX	Excision of Right Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBL7ZX	Excision of Left Lung, Via Natural or Artificial Opening, Diagnostic
0BBL8ZX	Excision of Left Lung, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BBM4ZX	Excision of Bilateral Lungs, Percutaneous Endoscopic Approach, Diagnostic
0BBM7ZX	Excision of Bilateral Lungs, Via Natural or Artificial Opening, Diagnostic
0BBM8ZX	Excision of Bilateral Lungs, Via Natural or Artificial Opening Endoscopic, Diagnostic
0B710DZ	Dilation of Trachea with Intraluminal Device, Open Approach
0B710ZZ	Dilation of Trachea, Open Approach
0B713DZ	Dilation of Trachea with Intraluminal Device, Percutaneous Approach
0B713ZZ	Dilation of Trachea, Percutaneous Approach
0B714DZ	Dilation of Trachea with Intraluminal Device, Percutaneous Endoscopic Approach
0B714ZZ	Dilation of Trachea, Percutaneous Endoscopic Approach
0B717DZ	Dilation of Trachea with Intraluminal Device, Via Natural or Artificial Opening
0B717ZZ	Dilation of Trachea, Via Natural or Artificial Opening
0B718DZ	Dilation of Trachea with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B718ZZ	Dilation of Trachea, Via Natural or Artificial Opening Endoscopic
0B720DZ	Dilation of Carina with Intraluminal Device, Open Approach
0B720ZZ	Dilation of Carina, Open Approach
0B723DZ	Dilation of Carina with Intraluminal Device, Percutaneous Approach
0B723ZZ	Dilation of Carina, Percutaneous Approach
0B724DZ	Dilation of Carina with Intraluminal Device, Percutaneous Endoscopic Approach
0B724ZZ	Dilation of Carina, Percutaneous Endoscopic Approach
0B727DZ	Dilation of Carina with Intraluminal Device, Via Natural or Artificial Opening
0B727ZZ	Dilation of Carina, Via Natural or Artificial Opening
0B728DZ	Dilation of Carina with Intraluminal Device, Via Natural or Artificial Opening Endoscopic

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 Inpatient Coding (Continued)

ICD-10 PCS Code	ICD-10 PCS Description
0B728ZZ	Dilation of Carina, Via Natural or Artificial Opening Endoscopic
0BC17ZZ	Extirpation of Matter from Trachea, Via Natural or Artificial Opening
0BC18ZZ	Extirpation of Matter from Trachea, Via Natural or Artificial Opening Endoscopic
0BC37ZZ	Extirpation of Matter from Right Main Bronchus, Via Natural or Artificial Opening
0BC38ZZ	Extirpation of Matter from Right Main Bronchus, Via Natural or Artificial Opening Endoscopic
0BC77ZZ	Extirpation of Matter from Left Main Bronchus, Via Natural or Artificial Opening
0BC78ZZ	Extirpation of Matter from Left Main Bronchus, Via Natural or Artificial Opening Endoscopic
0B714DZ	Dilation of Trachea with Intraluminal Device, Percutaneous Endoscopic Approach
0B734DZ	Dilation of Right Main Bronchus with Intraluminal Device, Percutaneous Endoscopic Approach
0B744DZ	Dilation of Right Upper Lobe Bronchus with Intraluminal Device, Percutaneous Endoscopic Approach
0B754DZ	Dilation of Right Middle Lobe Bronchus with Intraluminal Device, Percutaneous Endoscopic Approach
0B774DZ	Dilation of Left Main Bronchus with Intraluminal Device, Percutaneous Endoscopic Approach
0B784DZ	Dilation of Left Upper Lobe Bronchus with Intraluminal Device, Percutaneous Endoscopic Approach
0B718DZ	Dilation of Trachea with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B738DZ	Dilation of Right Main Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B748DZ	Dilation of Right Upper Lobe Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B758DZ	Dilation of Right Middle Lobe Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B778DZ	Dilation of Left Main Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0B788DZ	Dilation of Left Upper Lobe Bronchus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic

Medicare Hospital Inpatient Payment

Rates Effective October 1, 2017 - September 30, 2018

Medicare Severity Diagnosis Related Groups (MS-DRGs) resulting from inpatient bronchoscopy procedures may include (but are not limited to):

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
163	Major Chest Procedures with MCC[5,7]	$29,843
164	Major Chest Procedures with CC[5]	$15,544
165	Major Chest Procedures without CC/MCC	$11,156
180	Respiratory neoplasms with Major Complication or Comorbidity (MCC[5])	$10,184
181	Respiratory neoplasms pancreas with Complication or Comorbidity (CC[5])	$6,969
182	Respiratory neoplasms without CC/MCC	$5,093
189	Pulmonary edema & respiratory failure	$7,353
193	Simple pneumonia & pleurisy with MCC[5]	$8,278
194	Simple pneumonia & pleurisy with CC[5]	$5,626
195	Simple pneumonia & pleurisy without CC/MCC	$4,280
196	Interstitial lung disease with MCC[5]	$9,623
197	Interstitial lung disease with CC[5]	$6,299
198	Interstitial lung disease without CC/MCC	$4,717
204	Respiratory signs & symptoms	$4,619
205	Other respiratory system diagnoses with MCC[5]	$8,999
206	Other respiratory system diagnoses without CC/MCC	$5,135

Please refer to page 10 for footnotes
See important information about the uses and limitations of this document on pages 2 and 3

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 OPPS C-APC payment of the primary service with minor exceptions.
‡	The 2018 National Average Medicare physician payment rates have been calculated using a 2018 conversion factor of $35.9996. Rates subject to change.
NA	"NA" indicates that there is no in-office differential for these codes.
N/A*	N/A* Medicare has not developed a rate for the ASC setting as the procedure is typically performed in the hospital setting.
1	CPT copyright 2017 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 2017 release, CMS-1676-F file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
3	Source: December 27, 2017 Federal Register CMS-1678-CN.
4	National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($6,028.08). Source: August 2, 2017 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, 2018.

Boston Scientific

Advancing science for life™

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

ENDO-519904-AA JAN2018
Effective: 1JAN2018
Expires: 31DEC2018
MS-DRG Rates Expire: 30SEP2018

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