2021 Coding & Payment Quick Reference

Bronchial Thermoplasty

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.

Diagnosis Coding

ICD-10 CM Diagnosis Code	Description
J45.50	Severe persistent asthma, uncomplicated

Medicare Physician and Hospital Outpatient Payments

		RVUs			2021 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
Bronchial Thermoplasty								
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	4.00	NA	5.70	NA	$199	$5,823	$3,111
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	4.25	NA	6.02	NA	$210	$5,823	$3,094

C-Code Information

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

Code	Description
C1886	Catheter, extravascular tissue ablation, any modality (insertable)

On claims for Medicare beneficiaries, hospitals should report not only the appropriate CPT® Code, but also C-Code C1886.

- 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.

Suggested Revenue Codes

Code	Description
278‡	Medical/surgical supplied and devices/other implants
272	Sterile supply/medical/surgical supplies and devices

See important notes on the uses and limitations of this information on page 2.

ASC

The Category I CPT® Codes 31660 and 31661 for BT are not currently on the "ASC Covered Surgical Procedures" for CY 2021 and therefore this procedure is not covered in the ASC setting for Medicare patients. ASCs should contact commercial payers to determine whether the procedure would be covered in this setting.

Note: The Instructions for Use for the Alair System specify that facilities should be equipped with access to full resuscitation equipment to handle hemoptysis, pneumothorax, and other respiratory complications, including acute exacerbation of asthma and respiratory failure requiring intubation.

Coverage

The Alair™ System is FDA approved, and some payers are covering the procedure while others are reviewing the technology for coverage. Providers should contact their individual payers prior to performing the procedure for information on coverage.

Medicare includes Bronchial Thermoplasty as part of a covered benefit category and has approved the procedure for qualified patients nationwide, but does not have a formal written coverage policy for the procedure. Healthcare facilities and physicians treating patients who have Medicare coverage will need to submit a claim to their local Medicare contractor.

Boston Scientific recommends pre-authorization of benefits for BT with third-party payers who do not cover BT but will allow a pre-authorization of benefits. Boston Scientific offers support for providers in working through the pre-authorization process in instances where consistent formal coverage has yet to be established. Customers performing BT delivered by the Alair System can contact the BT CareConnect for pre-authorization and appeal support.

BT CareConnect Contact Information:

1-844-693-7402 (phone) | 1-844-693-7403 (fax) | BSC.BTPSP@bsci.com

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 December 2020 but is subject to change without notice. Rates for services are effective January 1, 2021.

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

** For Medicare claims, please note that CPT Codes 31660 and 31661 map to Ambulatory Payment Classification (APC) 5155, Level 5 Airway Endoscopy.

† 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.

‡ According to Medicare, devices do not need to remain in the body to be classified as "implants."[4,5]

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

1 Current Procedural Rate (CPT) 2020 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 - December 2020 release, RVU21A file https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f.

3 National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($6,427.52). Source: October 2020 Federal Register.

4 Preamble to the Inpatient Prospective Payment update regulation for FY 2009 (73 FR 48462).

5 Revenue Code 278 - Definition in UB-04 manual, National Uniform Billing Committee Summary, August 2009, Page 5: (a) Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes. Examples of Other Implants (not all-inclusive): Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds.

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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