Boston Scientific
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2023 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, Hospital Outpatient, and ASC Payments

				RVUs		2023 Medicare National Average Payment			
						Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Bronchial Thermoplasty									
5155†	31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	4.00	NA	5.77	NA	$196	$6,187	N/A
5155†	31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	4.25	NA	5.84	NA	$198	$6,187	N/A

C-Code Information

For all C-Code information, please reference the C-Code Finder.

Suggested Revenue Codes

Code[1]	Description
278‡	Medical/surgical supplies 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

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 (BT) 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.

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 January 2023 but is subject to change without notice. Rates for services are effective January 1, 2023.

† Comprehensive APCs (C-APCs): CMS implemented their C-APC policy with the goal of identifying certain high-cost device-related outpatient procedures (formerly "device intensive" APCs). CMS identifies 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. Certain exceptions are defined under CMS's C-APC "complexity adjustment" policy and can be found in the OPPS Addenda files (Addendum J).

‡ The 2023 National Average Medicare physician payment rates have been calculated using a 2023 conversion factor of $33.8872. 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 Rate (CPT) 2022 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. Centers for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2023 release CMS-1770-F | CMS
3. Center for Medicare and Medicaid Services. CMS Hospital Outpatient and Ambulatory Surgery Center Payment Schedules – January 2023 release, CMS-1772-FC | CMS

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.

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