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GUIDEPOINT
Reimbursement Resources

2015 Coding & Payment Quick Reference

Select Pulmonary Procedures

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.

Rates referenced in this guide 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, 2015.

Medicare Physician, Hospital Outpatient, and ASC Payments

The bronchoscopy procedures listed below (except CPT® Codes 31622, 31660, and 31661) all include a diagnostic bronchoscopy when performed by the same physician.

		RVUs			2015 Medicare National Average Payment			
					Physician‡,2		Facility3	
CPT® Code[1]	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Biopsy								
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	3.36	9.49	4.92	$339	$176	$1,055	$578
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	3.80	10.60	5.48	$379	$196	$1,055	$578
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	2.03	1.41	$73	$50	$0	$0
Cytology and Brush								
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	2.78	8.92	4.20	$319	$150	$1,055	$578
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	2.88	9.43	4.23	$337	$151	$1,055	$578
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	2.88	8.93	4.27	$319	$153	$1,055	$578
Foreign Body Removal (Stent Removal)								
31635	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of foreign body	3.67	9.97	5.45	$356	$195	$1,055	$578

See important notes on the uses and limitations of this information on page 4.

Effective: 1JAN2015
Expires: 31DEC2015
MS-DRG Rates Expire: 30SEP2015
ENDO-47409-AD DEC2014

		RVUs			2015 Medicare National Average Payment Physician‡,2		Facility3	
CPT® Code1	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Needle Aspiration								
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	4.09	16.78	5.91	$600	$211	$2,255	$1,237
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	2.51	1.83	$90	$65	$0	$0
31645	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)	3.16	9.22	4.66	$330	$167	$1,055	$578
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	6.70	6.70	$240	$240	$2,255	$1,237
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	6.41	6.41	$229	$229	$2,255	$1,237
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	2.14	2.14	$77	$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	7.34	7.34	$262	$262	$2,255	$1,237
Balloon Dilation								
31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	3.81	5.79	5.79	$207	$207	$2,255	$1,237
Bronchial Thermoplasty								
31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	4.25	6.02	6.02	$215	$215	$2,255	N/A*
31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	4.50	6.30	6.30	$225	$225	$2,255	N/A*

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Medicare Hospital Inpatient Coding:

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
32.27	Bronchoscopic bronchial thermoplasty, ablation of airway smooth muscle
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
33.91	Bronchial dilation

Medicare Hospital Inpatient Payment:
Rates Effective October 1, 2014 - September 30, 2015

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]
180	Respiratory neoplasms with Major Complication or Comorbidity (MCC[5])	$9,895
181	Respiratory neoplasms pancreas with Complication or Comorbidity (CC[5])	$6,793
182	Respiratory neoplasms without CC/MCC	$4,744
189	Pulmonary edema & respiratory failure	$7,118
193	Simple pneumonia & pleurisy with MCC[5]	$8,500
194	Simple pneumonia & pleurisy with CC[5]	$5,683
195	Simple pneumonia & pleurisy without CC/MCC	$4,132
196	Interstitial lung disease with MCC[5]	$9,757
197	Interstitial lung disease with CC[5]	$6,226
198	Interstitial lung disease without CC/MCC	$4,724
204	Respiratory signs & symptoms	$4,130
205	Other respiratory system diagnoses with MCC[5]	$8,211
206	Other respiratory system diagnoses without CC/MCC	$4,658
163	Major Chest Procedures with MCC[5,7]	$29,522
164	Major Chest Procedures with CC[5]	$15,256
165	Major Chest Procedures without CC/MCC	$10,687

See important notes on the uses and limitations of this information on page 4.

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‡ The 2015 National Average Medicare physician payment rates have been calculated using a 2015 conversion factor of $35.7547 which reflects changes for January 1, 2015 through March 31, 2015. Rates subject to change.

N/A* Medicare has not developed a rate for the ASC setting as the procedure is typically performed in the hospital setting.

* Add-on codes are always listed in addition to the primary procedure code.

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2 Center for Medicare and Medicaid Services. CMS Physician Fee Schedule - January 8, 2015 revised release, RVU15A file http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU15A.html?DLPage=1&DLSort=0&DLSortDir=descending

3 Source: November 10, 2014 Federal Register CMS-1613-FC.

4 National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,865.48). Source: August 22, 2014 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.

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