INTUITIVE

Ion Endoluminal System 2025 U.S. Coding and Reimbursement Guide—Facilities

Medicare national average rates

For additional assistance, please email us reimbursementhelp@intusurg.com.

Table of contents

For additional assistance, please email us reimbursementhelp@intusurg.com.

How to use this guide: intended use and audience

The intention of this guide is

To provide general coding and reimbursement information based on publicly-available Medicare data for informational purposes only.

To provide U.S. national average reimbursement rates based on Medicare publicly-available fee schedules.

To provide relevant supporting information about U.S. coding and reimbursement.

The intended audience for this presentation is

Healthcare professionals involved in coding, documentation, claims processing, and/or reimbursement for relevant procedures. This may include hospital and/or physician office billing professionals, coders, financial, and/or revenue integrity teams, and others who act in roles associated with the coding, coverage, and payment of relevant procedures.

It is NOT intended for

Healthcare providers and/or allied health professionals or other hospital and/or office staff who do not act in above roles and capacities.

For additional assistance, please email us reimbursementhelp@intusurg.com.

Disclaimer

Intuitive is providing this resource for informational purposes only, in support of accurate coding and reimbursement practices based on Medicare coding, coverage, and payment. Intuitive cannot guarantee that this document is complete or without errors, as coding, coverage, and payment are subject to change at any time.

This coding and reimbursement guide cannot, under any circumstances, be interpreted as, or used in place of, clinical judgment.

Any coding and reimbursement decisions and practices are the sole responsibility of the provider and/or designated party responsible for coding and reimbursement.

Intuitive may not carry all products used in all procedures described. For more information, go to intuitive.com/safety.

CPT is a registered trademark of the American Medical Association.

The responsibility for the content of any "National Correct Coding Policy" included in this product is with the Centers for Medicare and Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.

For additional assistance, please email us reimbursementhelp@intusurg.com.

Methodology and background

This guide includes Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare and other health insurers to standardize coding in claims and other documentation. It is the responsibility of the provider and/or designated party responsible for coding and reimbursement to determine the appropriate code(s) based on the situation.*

HCPCS codes are comprised of 2 levels, referred to as Level I and Level II of the HCPCS:

Level I includes the Physicians' Current Procedural Terminology Fourth Edition (CPT).† CPT is based on a numeric coding system maintained by the American Medical Association (AMA) that describes medical services and procedures provided by physicians and other healthcare professionals.

In 2007, the AMA determined that no new CPT codes or unique identifiers were needed when describing laparoscopic/endoscopic procedures performed with robotic assistance.

Level II codes are used to report durable medical equipment, supplies, nonphysician services, and some drugs.

* This guide is provided for educational purposes, and is not a comprehensive list of procedures. As the AMA publishes CPT codes on an annual basis, and makes decisions regarding the addition, deletion, or revision of CPT codes throughout the year, this guide may not reflect interim updates. Please refer to the most recent AMA publication of CPT® codes for additional information.

† CPT© 2025 American Medical Association. All Rights Reserved. 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.

For additional assistance, please email us reimbursementhelp@intusurg.com.

Reimbursement terminology and abbreviations

Reimbursement terminology used in this guide are briefly defined below in support of 2025 Medicare reimbursement information. Unless otherwise noted, all definitions and sources available at the Centers of Medicare and Medicaid Services (CMS) Glossary: www.cms.gov/apps/glossary.

American Medical Association (AMA): Professional organization for physicians that maintains the Physicians' Current Procedural Terminology (CPT) coding system.

Ambulatory Payment Classification (APC): Developed by CMS as the basis for hospital outpatient reimbursement rates; relevant CPT codes are grouped into APCs based on resource utilization.

Comprehensive Ambulatory Payment Classification (C-APC): Identified by the status indicator of J1, C-APC's provide a single payment for services that were frequently being billed together. The single payment for a comprehensive claim is based on the rate associated with the J1 service. When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service. When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family. Note that complexity adjustments will not be applied to discontinued services (reported with modifier -73 or -74).

Ambulatory Surgery Center (ASC): Site of care for some services and procedures where patients are admitted, treated, and discharged within 24 hours.

Centers for Medicare & Medicaid Services (CMS): Federal government agency within the Department of Health and Human Services that administers public health programs. (See also "PPS".) Current Procedural Terminology (CPT): See HCPCS Level I.

Fee Schedule: List of codes and services with payment amounts (also referred to as reimbursement rates).

Healthcare Common Procedure Coding System (HCPCS) Level I: Numeric coding system used by physicians, other health professionals, hospitals, and ambulatory surgical centers (ASC) to code procedures and services. HCPCS Level I is comprised of the American Medical Association's Physicians' Current Procedural Terminology (CPT) codes. CPT codes have been adopted by the Secretary of Health and Human Services as a standard to describe medical services and procedures provided by physicians and other healthcare professionals.

Prospective Payment System (PPS): A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

For additional assistance, please email us reimbursementhelp@intusurg.com.

2025 Medicare reimbursement

All rates shown in the following section reflect 2025 Medicare national average rates, unadjusted by geography or other factors.

Medicare hospital outpatient data files, including Ambulatory Surgical Center (ASC) information, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices

For additional assistance, please email us reimbursementhelp@intusurg.com.

Facility coding and billing information

The following facility coding and payment information is intended for educational purposes only and does not reflect every coding scenario available, therefore, facility payment will vary depending on services rendered. Multiple procedures may be performed on the same date of service; packaging and multiple endoscopy rules are applied based on the procedures performed and will determine the correct Ambulatory Payment Classification (APC) payment. Please consult your internal coding and compliance guidelines.

For additional assistance, please email us reimbursementhelp@intusurg.com.

Facility coding and billing information

SKU	Supplies used	Brand name	Existing HCPC code available
Reposables			
490206	Enhanced vision probe instrument	Ion peripheral vision probe	
490305	Catheter instrument	Ion fully articulating catheter	C1887
490107	Catheter guide		
Disposables			
490102	23g biopsy needle	Flexision® biopsy needle	
490103	21g biopsy needle	Flexision biopsy needle	
490104	19g biopsy needle	Flexision biopsy needle	
490108	Swivel connector		
490101	Vision probe adaptor and suction adaptor		

For additional assistance, please email us reimbursementhelp@intusurg.com.

Facility coding and billing information

Listed below are commonly used procedure codes during bronchoscopy where navigation may be performed. Providers may choose to perform multiple procedures during the same encounter. When this occurs, the payment may be subject to packaging rules or a complexity adjusted payment.

CPT 31627 describes computer-assisted navigation and when performed is packaged into the payments listed below. There is no separate payment to the facility.

CPT	Procedure description	Status indicator	APC	2025 National average payment rate
Bronchoscopy with biopsy in a hospital outpatient department (POS 22)				
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	J1	5153	$1,724
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	J1	5153	$1,724
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	J1	5153	$1,724
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers	J1	5155	$6,922
31627	Computer-assisted, image-guided navigation	N		Packaged
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	J1	5154	$3,687
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)	N		Packaged
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s) trachea, main stem, and/or lobar bronchus	J1	5154	$3,687
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)	N		Packaged

For additional assistance, please email us reimbursementhelp@intusurg.com.

Facility coding and billing information

CPT	Procedure description	Status indicator	APC	2025 National average payment rate
Concominant procedures	The procedures listed below may be performed using navigation assistance and describes Medicare guidance. It is not intended to suggest these code combinations are required to be performed together. Medical decision making should be made based upon what is in the best interest of the patient. EBUS sampling may not be performed alone with the Ion system.			
31629 + 31628	Bronchoscopy with needle biopsy, bronchoscopy with lung biopsy	J1	5155	$6,922
31653 + 31628	Bronchoscopy with sampling 3+ nodes, bronchoscopy with lung biopsy	J1	5155	$6,922
31653 + 31629	Bronchoscopy with sampling 3+ nodes, bronchoscopy with needle biopsy	J1	5155	$6,922
31628 + 31652	Bronchoscopy with lung biopsy, bronchoscopy with sampling 1-2 nodes	J1	5155	$6,922

For additional assistance, please email us reimbursementhelp@intusurg.com.

Ion endoluminal system
The Ion endoluminal system (Model IF1000) assists the user in navigating a catheter and endoscopic tools in the pulmonary tract using endoscopic visualization of the tracheobronchial tree for diagnostic and therapeutic procedures. The Ion endoluminal system enables fiducial marker placement. It does not make a diagnosis and is not for pediatric use.

Information provided by the Ion endoluminal system or its components should be considered guidance only and not replace clinical decisions made by a trained physician.

For summary of the risks associated with bronchoscopy refer to www.intuitive.com/safety.

INTUITIVE

For additional assistance, please email us reimbursementhelp@intusurg.com.