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Ion Endoluminal System 2024 U.S. Coding and Reimbursement Guide—Physician

Medicare national average rates

Effective March 9, 2024

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

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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.

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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.

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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© 2024 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.

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Reimbursement terminology and abbreviations

Reimbursement terminology used in this guide are briefly defined below in support of 2024 Medicare reimbursement information. Unless otherwise noted, all definitions and sources available at the Centers of Medicare and Medicaid Services (CMS) Glossary: cms.gov/apps/glossary.

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

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 health care professionals.

Medicare physician fee schedule: Annual fee schedule published by CMS based on work, expense, and malpractice designed to standardize physician payment.

Multiple procedure payment indicator: Payment indicator 0-3 amended to certain procedures when occurring at the same time and reflects reduced payment based upon the overlap of the pre and post procedure work. This applies to physician reimbursement for services performed.

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).

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2024 Medicare reimbursement

All rates shown in the following section reflect 2024 Medicare national average rates, unadjusted by geography or other factors.

Medicare physician fee schedule data files available at cms.gov/medicare/payment/fee-schedules/physician.

National average Medicare physician fee schedule rates based on 2024 conversion factor of $33.2875, per "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2024." Available at cms.gov/medicare/payment/fee-schedules/physician.

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Physician coding and payment information

The following coding information is intended for educational purposes only and do not reflect every bronchoscopy with biopsy using Ion® coding scenario available, therefore, reimbursement will vary depending on services rendered. Providers may choose to perform multiple procedures on the same date of service; packaging and multiple procedure rules are applied based on the procedures performed. Providers should report all procedures performed. Please consult your internal coding and compliance guidelines.

Multiple Procedure Payment Indicator(MPPI)

0: No payment adjustment rules apply. If the procedure is reported on the same day as another procedure, the procedure is paid at the lower of the actual charge or the fee schedule amount for the procedure.

2: Standard payment rules apply. If the procedure is reported on the same day as another procedure with a numeric designation of 2 or 3, rank each procedure by the fee schedule amount and take the appropriate reduction: Highest valued procedure: 100%, Second, third, fourth, and fifth valued procedures: 50% for each procedure beyond the fifth.

3: Special rules for multiple endoscopic procedures apply when the procedure is performed with another endoscopic procedure in the same family.

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Physician coding and payment information

CPT	Potential procedures—description	Total Facility RVUs	2024 MPFS Facility Payment	MPPI
Bronchoscopy with biopsy				
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	3.90	$130	2
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	3.87	$129	3
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	3.92	$130	3
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers	5.78	$192	2
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	5.15	$171	3
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s) trachea, main stem, and/or lobar bronchus	5.47	$182	3
Computer-assisted, image-guided navigation				
+31627	Bronchoscopy, with computer-assisted, image-guided navigation (list separately in addition to code for primary procedures)	2.82	$94	0
For multiple lobes report				
+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)	1.43	$48	0
+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)	1.84	$61	0

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Important safety information
Risks associated with bronchoscopy through an endotracheal tube and under general anesthesia are infrequent and typically minor and may include but are not limited to: sore throat, hoarseness, respiratory complications including dyspnea or hypoxemia, airway injury, bronchospasm, laryngospasm, fever, hemoptysis, chest or lung infection including pneumonia, lung abscess, or an adverse reaction to anesthesia. Although rare, the following complications may also occur: bleeding, pneumothorax (collapsed lung), cardiac related complications, respiratory failure, air embolism, or death. As with other medical procedures, there may be additional risks associated with the use of general anesthesia and/or endotracheal intubation that are not listed above; you should consult a healthcare professional regarding these and other potential risks.

Procedures using the Ion robotic bronchoscopy system may be associated with longer procedure and/or longer anesthesia time.

Individuals' outcomes may depend on a number of factors, including but not limited to patient characteristics, disease characteristics, and/or surgeon experience.

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