U.S. Reimbursement & Coding Guide for Select Bronchoscopy Procedures

Medicare National Payment Rates

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Terminology & Abbreviations

Reimbursement terminology used in this guide are briefly defined below. Unless otherwise noted, all definitions and sources are 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 most services provided during the hospital outpatient admission. 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).

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):

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

Medicare physician fee schedule (MPFS): 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, APCs for outpatient hospital services).

Transitional Pass-Through Payment Status (TPT): This is a program applicable to Medicare Fee-For-Service patients where CMS may provide incremental hospital payment for qualifying device categories. The intent of the TPT is to facilitate access for Medicare patients to the advantages of new and truly innovative devices.

Physician Coding and Billing Information[1]

The following coding information is intended for educational purposes only, reimbursement will vary depending on services rendered. Providers may choose to perform multiple procedures on the same date or 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.

Bronchoscopy with biopsy

CPT® Code	CPT® Description:	2024 Total Non-Facility RVUs	2024 MPFS Non- Facility Payment	2024 Total Facility RVUs	2024 MPFS Facility Payment	MPPI**
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	7.48	$245	3.90	$128	2
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	8.21	269	3.87	127	3
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	7.64	$250	3.92	$128	3
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	10.43	$342	4.58	$150	3
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	23.44	$768	5.78	$189	2
31628*	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	11.11	$364	5.15	$169	3
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s) trachea, main stem and/or lobar bronchus	13.52	$443	5.47	$179	3

[1] CMS-1784-F; https://www.cms.gov/medicare/physician-fee-schedule/search, accessed December 29, 2023

Physician Coding and Billing Information

Computer assisted, image-guided navigation

CPT® Code	CPT® Description:	2024 Total Non-Facility RVUs	2024 MPFS Non- Facility Payment	2024 Total Facility RVUs	2024 MPFS Facility Payment	MPPI**
+31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (list separately in addition to code for primary procedures)	31.81	$1,042	2.82	$92	0

+ indicates code is an add-on code

Bronchoscopy with biopsy(s) of additional lobe

CPT® Code	CPT® Description:	2024 Total Non-Facility RVUs	2024 MPFS Non- Facility Payment	2024 Total Facility RVUs	2024 MPFS Facility Payment	MPPI**
+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)	1.93	$63	1.43	$47	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)	2.40	$79	1.84	$60	0

+ indicates code is an add-on code

**MPPI – Multiple Procedure Payment Indicator

0: No payment adjustment rules for multiple procedures 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 for multiple procedures apply. If the procedure is reported on the same day as another procedure with a numeric designation of 1, 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 (i.e., another endoscopy that has the same base procedure).

Facility Coding and Billing Information[2]

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 packing rules or a complexity adjusted payment.

Bronchoscopy with biopsy in a Hospital Outpatient Department

CPT® Code	CPT® Description	Status Indicator	APC	2024 National Payment Rate
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	J1	5153	$1,619
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	J1	5153	$1,619
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	J1	5153	$1,619
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	J1	5153	$1,619
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers	J1	5155	$6,528
+31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (list separately in addition to code for primary procedures)	N	-	Packaged
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	J1	5154	$3,572
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	$3,572
+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
+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

+ indicates code is an add-on code

[2] CMS-1786-FC, Addenda A, B, J

Facility coding and billing information[3]

Select CY 2024 Hospital Outpatient complexity adjustment pairings

Primary CPT® code	Primary procedure short descriptor	Secondary CPT® code	Secondary procedure short descriptor	Complexity adjusted APC assignment	Complexity adjusted APC Payment rate
31629	Bronchoscopy/needle bx each	31628	Bronchoscopy/lung bx each	5155	$6,528
31629	Bronchoscopy/needle bx each	31629	Bronchoscopy/needle bx each	5155	$6,528
31629	Bronchoscopy/needle bx each	31641	Bronchoscopy treat blockage	5155	$6,528
31629	Bronchoscopy/needle bx each	31653	Bronchoscopy EBUS sampling 3/> node	5155	$6,528
31653	Bronchoscopy EBUS sampling 3/> node	31628	Bronchoscopy/lung bx each	5155	$6,528
31653	Bronchoscopy EBUS sampling 3/> node	31640	Bronchoscopy w/tumor excise	5155	$6,528
31653	Bronchoscopy EBUS sampling 3/> node	31641	Bronchoscopy treat blockage	5155	$6,528
31622	Dx bronchoscope/ wash	31627	Navigational bronchoscopy	5154	$3,572
31624	Dx bronchoscope/ lavage	31627	Navigational bronchoscopy	5154	$3,572
31624	Dx bronchoscope/ lavage	31654	Bronch ebus ivntj perph lesion	5154	$3,572
31625	Bronchoscopy w/biopsy(s)	31623	Dx bronchoscope/brush	5154	$3,572
31625	Bronchoscopy w/biopsy(s)	31624	Dx bronchoscope/lavage	5154	$3,572
31625	Bronchoscopy w/biopsy(s)	31627	Navigational bronchoscopy	5154	$3,572
31625	Bronchoscopy w/biopsy(s)	31635	Bronchoscopy with fb removal	5154	$3,572
31625	Bronchoscopy w/biopsy(s)	31645	Brnchsc with ther aspir 1st	5154	$3,572
31625	Bronchoscopy w/biopsy(s)	31654	Bronch ebus ivntj perph lesion	5154	$3,572

[3] CMS-1786-FC, Addenda A, J

CMS Transitional Pass-Through Payment Status (TPT)

TPT is a program administered by CMS that provides incremental payment in the hospital outpatient setting for qualifying categories of technologies.[4] Once approved by CMS, the TPT lasts for three years and allows CMS to collect hospital claims information for calculation of future hospital outpatient APC payment rates.

In the CY 2024 Final Hospital Outpatient Prospective Payment System Rule, CMS approved a TPT application associated with single-use pulmonary endoscopes.[5] As a result, effective January 1, 2024, CMS created a new device category to identify technologies that qualify for this specific TPT:

C1601, Endoscope, single-use (i.e. disposable), pulmonary, imaging/illumination device (insertable).

Further, CMS identified various primary procedures to which C1601 is applicable, including[6]:

CPT® Code	Procedure Description	APC	2024 National Payment Rate	Device Offset
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	5153	$1,619	$8.57
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	5153	$1,619	$6.47
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	5153	$1,619	$2.91
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	5153	$1,619	$14.88
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers	5155	$6,528	$652.77
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	5154	$3,572	$36.04
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s) trachea, main stem and/or lobar bronchus	5154	$3,572	$44.96

CMS has stated that TPT is not necessarily specific to one technology. Instead, CMS creates device categories (e.g., C1601) that allow any technology that is appropriately described by that device category to bill for TPT during the three-year duration. It is advised that each provider confirms the use of any code, including C1601, with the provider's billing advisor or payer.

TPT applies to traditional Fee-For-Service Medicare patients. Please check with other payers to determine if TPT applies. For Medicare, the TPT payment is calculated on a claim-by-claim basis, and is based on the following factors:

- The primary procedure that is performed with a device described by C1601,
- The device offset associated with that procedure,
- The charges established by the hospital for C1601 in its chargemaster, and
- The hospital's cost-to-charge ratio (CCR) for the revenue center "Implantable Devices Charged to Patients" or "Medical Supplies" (if the former is not available)

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[4] https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/pass-through-payment-status-new-technology-ambulatory-payment-classification-apc

[5] https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc

[6] https://www.cms.gov/regulations-and-guidance/guidance/transmittals/2023-transmittals/r12421cp

TPT Examples – For Illustrative Purposes Only

Example 1:

Charges for Device Category C1601:.. $7,500

Implantable Devices Charged to Patients CCR:.............................. 0.2689

Primary Procedure CPT Code:.. 31628

	Element	Calculation	Amount
Hospital charges for C1601	A		$7,500
Hospital Implantable Devices CCR	B		x 0.2689
Reported Cost of C1601	C	A x B	$2,017
Device Related Offset of CPT Code 31628	D		- $36
Incremental TPT Payment	E	C – D	$1,981
APC Assignment for CPT Code 31628 (APC 5154)	F		+ $3,572
Total APC+ TPT Payment	G	E + F	$5,553

Example 2 (Complexity Adjusted):

Charges for Device Category C1601:.. $7,500

Implantable Devices Charged to Patients CCR:.............................. 0.2689

Primary and Secondary Procedure CPT Codes:................31629 + 31629

	Element	Calculation	Amount
Hospital charges for C1601	A		$7,500
Hospital Implantable Devices CCR	B		x 0.2689
Reported Cost of C1601	C	A x B	$2,017
Device Related Offset of CPT Code 31629	D		- $45
Incremental TPT Payment	E	C – D	$1,972
Complexity Adjusted APC Assignment (APC 5155)	F		+ $6,528
Total APC+ TPT Payment	G	E + F	$8,500

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