Medtronic

Engineering the extraordinary

2024 Billing and Coding Guide

Lung Health procedures

Overview

This guide is intended to aid providers in appropriate procedure code selection for Lung Health related procedures. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the CPT®[1] code.

Instructions for use:

- New tools and updates can be found in the New for 2024 section.
- Code descriptions and details of code reporting requirements and/or guidance, as well as Physician, Hospital Outpatient, and/or Ambulatory Surgery Center (ASC) rates, can be found in the Coding & Reimbursement section.
- Details surrounding specialized coding and reimbursement information can be found in FAQ and resources section.
- This document is not all-inclusive, nor does it replace advice from your coding and compliance departments and/or CPT®[1] coding manuals.

New for 2024

New Tool

Medtronic C-code Finder

Launching January 2024, we will have a new tool specifically designed to access applicable commonly used C-codes as it relates to Medtronic products. Medicare provides C-codes, a type of HCPCS[3] II code, for hospital use in billing Medicare for some medical devices and supplies in the hospital outpatient setting. The C-code finder can be accessed at www.medtronic.com/c-code or by using the C-code button.

C-code Finder

Lung Screening Guidelines

ACS updated their Lung Cancer Screening Guidelines:

"The most important change in the updated guideline is that the number of years since quitting smoking is no longer a qualifier for starting or stopping yearly screening. That means a person who used to smoke with at least a 20 pack-year history, whether they quit yesterday or 20 years ago, is considered to have a high risk for developing lung cancer and should be recommended for a yearly LDCT scan…"

The ACS changes to their Lung Cancer Screening Guidelines are not reflective of CMS Beneficiary eligibility criteria. Further details on ACS and CMS beneficiary eligibility criteria can be found at:

- ACS
- CMS Beneficiary Eligibility Criteria

New for 2024

Changes to complexity adjustment code pairings[2] for OPPS

As of January 2024, there were multiple edits (additions and deletions) to the code pairs that qualify for a complexity adjustment in the hospital outpatient setting.

Click here for additional information on outpatient complexity adjustments.

New complexity adjustment code pairing[2] for the ASC

Medicare will now require ASCs to report C7556 (Bronch lavage w/ebus) when a bronchial lavage (31624) and an endobronchial ultrasound (31654) is performed.

Click here for additional information on ASC complexity adjustments.

Coding, reimbursement & complexity adjustments

This section provides Medicare unadjusted national average allowable rates for physician, hospital outpatient, ambulatory surgery, and hospital inpatient settings. The coding information in this section does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes must be supported by clear documentation within the medical record.

Providers may choose to perform multiple procedures during the same encounter. When this occurs, providers must report all procedures, and the payment may be subject to packaging rules, multiple procedure reductions, complexity adjustments, or multiple endoscopy reductions.

- HCPCS[3] II codes
- CPT®[1] procedure codes & Physician[4], Hospital outpatient[2] and Ambulatory surgery center[2] reimbursement rates
- Complexity adjustment pairings[2]
- Inpatient[6] national unadjusted reimbursement rates and ICD-10-PCS[7] codes

HCPCS[3] Level II codes

C-code Finder

Level II HCPCS[3] codes are primarily used to report supplies, drugs, and implants that are not reported by a CPT®[1] code. HCPCS codes are reported by the physician, hospital, or DME provider that purchased the item, device, or supply. Different payers have different payment methods for these items.

There are no designated Level II HCPCS codes assigned for electromagnetic navigation bronchoscopy (ENB) procedures.

Coding & reimbursement

		Physician[4]				Hospital Outpatient[2]			Ambulatory Surgery[2]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Bronchoscopy										
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	000	2.53	$245††	$128††	5153	J1	$1,617†	A2	$757††
31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	000	2.63	$269††	$127††	5153	J1	$1,617†	A2	$757††
31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	000	2.63	$250††	$128††	5153	J1	$1,617†	A2	$757††
31625	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites	000	3.11	$342††	$150††	5153	J1	$1,617†	A2	$757††
Placement of fiducial or dye markers										
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	000	3.91	$768††	$189††	5155	J1	$6,521†	G2	$2,301††
Electromagnetic navigation bronchoscopy (ENB)										
+31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (List separately in addition to code for primary procedure[s])	ZZZ	2.00	$1,042	$92	NA	N	NA§	N1	NA§

Coding & reimbursement

		Physician[4]				Hospital Outpatient[2]			Ambulatory Surgery[2]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Bronchoscopy with transbronchial sampling										
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	000	3.55	$364††	$169††	5154	J1	$3,568†	A2	$1,567††
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s) trachea, main stern and/or lobar bronchus(i)	000	3.75	$443††	$179††	5154	J1	$3,568†	A2	$1,567††
Multiple lobes										
+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)	ZZZ	1.03	$63	$47	NA	N	NA§	N1	NA§
+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)	ZZZ	1.32	$79	$60	NA	N	NA§	N1	NA§

Coding & reimbursement

		Physician[4]				Hospital Outpatient[2]			Ambulatory Surgery[2]	
CPT®[1] code	Description	Global days	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Endobronchial ultrasound (EBUS) guided sampling										
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]0, one or two mediastinal and/or hilar lymph node stations or structures	000	4.46	$1,215††	$211††	5154	J1	$3,568†	G2	$1,567††
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), three or more mediastinal and/or hilar lymph node stations or structures	000	4.96	$1,261††	$234††	5154	J1	$3,568†	G2	$1,567††
+31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s)	ZZZ	1.40	$118	$64	NA	N	NA§	N1	NA§
Transthoracic needle aspiration/biopsy (TTNA/TTNB)										
32408	Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed	000	3.18	$825††	$146††	5072	J1	$1,545†	G2	$683††

Coding & reimbursement

Hospital Outpatient complexity adjustment pairings[2]

Primary CPT®[1] code	Primary short descriptor[5]	Secondary CPT®[1] code	Secondary short descriptor[5]	Complexity adjusted APC assignment[2]	Complexity adjusted CY24 OPPS rate[2]
31622	Dx bronchoscope/wash	+31627	Navigational bronchoscopy	5154	$3,568
31623	Dx bronchoscope/brush	31645	Brnchsc w/ther aspir 1st	5154	$3,568
31624	Dx bronchoscope/lavage	+31627	Navigational bronchoscopy	5154	$3,568
31624	Dx bronchoscope/lavage	+31654	Bronch ebus ivntj perph les	5154	$3,568
31625	Bronchoscopy w/biopsy(s)	31623	Dx bronchoscope/brush	5154	$3,568
31625	Bronchoscopy w/biopsy(s)	31624	Dx bronchoscope/lavage	5154	$3,568
31625	Bronchoscopy w/biopsy(s)	+31627	Navigational bronchoscopy	5154	$3,568
31625	Bronchoscopy w/biopsy(s)	31645	Brnchsc w/ther aspir 1st	5154	$3,568
31625	Bronchoscopy w/biopsy(s)	+31654	Bronch ebus ivntj perph les	5154	$3,568
31629	Bronchoscopy/needle bx each	31628	Bronchoscopy/lung bx each	5155	$6,521
31629	Bronchoscopy/needle bx each	31629	Bronchoscopy/needle bx each	5155	$6,521
31629	Bronchoscopy/needle bx each	31653	Bronch ebus samplng 3/> node	5155	$6,521
31653	Bronch ebus samplng 3/> node	31628	Bronchoscopy/lung bx each	5155	$6,521

Coding & reimbursement

Ambulatory Surgery complexity adjustment pairings[2]

HCPCS[3] code	HCPCS[3] short descriptor[5]	Primary CPT®[1] code	Primary CPT®[1] short descriptor[5]	Secondary Add-on CPT®[1] code	Secondary CPT®[1] short descriptor[5]	Complexity adjusted CY24 ASC rate[2]
C7509	Dx bronch w/navigation	31622	Dx bronchoscope/wash	+31627	Navigational bronchoscopy	$1,567
C7510	Bronch/lavag w/navigation	31624	Dx bronchoscope/lavage	+31627	Navigational bronchoscopy	$1,567
C7511	Bronch/bpsy(s) w/navigation	31625	Bronchoscopy w/biopsy(s)	+31627	Navigational bronchoscopy	$1,567
C7512	Bronch/bpsy(s) w/ebus	31625	Bronchoscopy w/biopsy(s)	+31654	Bronch ebus invntj perph les	$1,567
C7556	Bronch lavage w/ebus	31624	Dx bronchoscope/lavage	+31654	Bronch ebus ivntj perph les	$1,567

Coding & reimbursement

Inpatient[6] national unadjusted reimbursement rates

Under Medicare's MS-DRG[6] methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Surgical supplies and implanted devices are typically included in the flat payment and are not paid separately. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed.

Unlike lung resections, the PCS codes for diagnostic bronchoscopies do not map to a surgical DRG. Because the diagnostic bronchoscopy codes are not considered a significant OR procedure, they do not impact DRG assignment.

MS-DRG[6]	Description	Rate
Lung resection		
163	Major Chest Procedures W MCC	$33,003
164	Major Chest Procedures W CC	$17,857
165	Major Chest Procedures W/O CC/MCC	$13,138
Other lung surgery		
166	Other Respiratory System O.R. Procedures W MCC	$28,411
167	Other Respiratory System O.R. Procedures W CC	$12,742
168	Other Respiratory System O.R. Procedures W/O CC/MCC	$9,492

Coding & reimbursement

ICD-10-PCS[7] procedure codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly used ICD-10-PCS procedure codes, however codes listed below are not exhaustive as other codes may apply.

ICD-10-PCS[7] code	Description
Bronchoscopy	
0BJK8ZZ	Inspection of Right Lung, Via Natural or Artificial Opening Endoscopic
0BJ08ZZ	Inspection of Tracheobronchial Tree, Via Natural or Artificial Opening Endoscopic
Placement of fiducial or dye markers	
0WHQ8YZ	Insertion of Other Device into Respiratory Tract, Via Natural or Artificial Opening Endoscopic
Electromagnetic navigation bronchoscopy (ENB)	
8E0WXBF	Computer Assisted Procedure of Trunk Region, With Fluoroscopy
Bronchoscopy with transbronchial sampling	
0BBC8ZX	Excision of Right Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BDC8ZX	Extraction of Right Upper Lung Lobe, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BB38ZX	Excision of Right Main Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
0BD88ZX	Extraction of Left Upper Lobe Bronchus, Via Natural or Artificial Opening Endoscopic, Diagnostic
Endobronchial ultrasound (EBUS) guided sampling	
BB4CZZZ	Ultrasonography of Mediastinum
07B74ZX	Excision of Thorax Lymphatic, Percutaneous Endoscopic Approach, Diagnostic
Transthoracic needle aspiration/biopsy (TTNA/TTNB)	
0B9M3ZX	Drainage of Bilateral Lungs, Percutaneous Approach, Diagnostic
0B9D3ZX	Drainage of Right Middle Lung Lobe, Percutaneous Approach, Diagnostic
0BBC3ZX	Excision of Right Upper Lung Lobe, Percutaneous Approach, Diagnostic
0BBG3ZX	Excision of Left Upper Lung Lobe, Percutaneous Approach, Diagnostic
Thoracoscopic (VATS) segmentectomy, wedge resection	
0BBD4ZZ	Excision of Right Middle Lung Lobe, Percutaneous Endoscopic Approach
0BBJ4ZZ	Excision of Left Lower Lung Lobe, Percutaneous Endoscopic Approach

Frequently asked questions

What code can be used to capture the mapping that is performed prior to an electromagnetic navigation bronchoscopy (ENB) procedure?

According to the American Medical Association, the mapping is included in the description for 31627: Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed with computer-assisted, image guided navigation.[12]

What codes should be used to bill for the ILLUMISITE™ fluoroscopic navigation platform disposables (catheter, needle, forceps, brush, etc.)?

There are no designated HCPCS[3] Level ll codes to report the ILLUMISITE™ platform kit or disposables.

What is the most common coding error regarding navigation bronchoscopy?

Not billing +31627 when electromagnetic navigation bronchoscopy is performed. Even though it is a packaged code under Medicare, +31627 still should be billed. Not including accurate coding affects future payment, coverage, and complexity adjustments. On the physician side, Medicare does reimburse in full when +31627 is billed.

When reporting professional charges, what is the proper Multiple Procedure Reduction rule when multiple bronchoscopy procedures (in the same code family) are performed on the same day by the same provider?

The Multiple Endoscopy rule would apply in this case. Payment would equal the full value of the highest valued endoscopy plus the difference between the next highest and the base endoscopy. Access Field 31A of the MPFSDB to determine the base endoscopy.[4,13]

How should +31627 be listed on a claim?

+31627 is an add-on code that should be listed in addition to the primary procedures on the claim. See the Appendix for more information on add-on codes.

The description for CPT®[1] 31626 only states fiducial markers – is this also the correct code to report bronchoscopy with dye marking?

Yes. CPT®[1] Assistant article on Respiratory System Changes states the following guidance and can be cited in communication with payers: Fiducial markers placed prior to surgery or radiation involves the use of different types of markers (eg, dye, gold). The type of marker placed does not alter the use of code 31626.[8]

Frequently asked questions

Are ASCs obligated to report the new C-codes to receive the complexity adjustment? If so, can we report these codes to commercial payers?

When billing Medicare, ASCs should report the new C-codes. The CMS ASC claims processing system will not trigger a complexity adjustment when CPT®[1] code combinations are billed. Level II HCPCS[3] C-codes are designated for reporting Medicare outpatient charges. Providers should verify with their commercial payers regarding appropriately reporting these procedures.[2]

Can I code for 31628 and 31629 if a physician uses a needle and forceps to sample tissue from the same lesion?

Yes, there are no CCI edits to the contrary and the AMA and ATS both that it is appropriate to report both 31628 and 31629 when a physician performs a transbronchial forceps biopsy and transbronchial needle aspiration biopsy on the same peripheral lesion in a single lobe, as clinically necessary.[9,10,14]

The treatment plan is to perform the work defined in 31652 or 31653, but the lymph nodes cannot be sampled, what CPT code can be billed?

This case seems appropriate to report the EBUS code intended (31652 or 31653) with modifier 53. This will indicate the intended procedure (EBUS staging of lymph nodes) and show it was discontinued by the physician due to extenuating circumstances (i.e., the lymph nodes/stations were not of sufficient size to sample).[12]

Is it appropriate to bill 77012 during a navigation bronchoscopy used with cone beam CT?

Based on the code descriptions, it would be appropriate to report CBCT (77012: Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation) with a bronchoscopy code. The AMA only states that fluoroscopic guidance (codes 77001-77003) is included in the bronchoscopy codes. There is no mention of CT guidance (77011-77014) being bundled.[12]

My physician uses a disposable bronchoscope during navigation bronchoscopy procedures - is the code C1601 appropriate to report?

C1601 (Endoscope, single-use (i.e., disposable), pulmonary, imaging/illumination device (insertable)) is a transitional pass-through code that went into effect on January 1, 2024. This code reports a single-use, disposable endoscope for pulmonary procedures. An endoscope is a device consisting of a tube and an optical system for viewing the inside of a hollow organ or cavity. If appropriate, this code can be reported alongside the appropriate procedure codes when the device described is used. Payment will vary on a case-by-case basis and is dependent on price.[2]

Appendix

Term	Footnote	Definition
Add-on CPT®[1] codes	+	An Add-on Code (AOC) is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An AOC is rarely eligible for payment if it's the only procedure reported by a practitioner.
Carrier priced		Carrier priced codes are not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis.
Complexity adjustment		The complexity adjustments were implemented by CMS to provide for a payment adjustment when two or more high-cost procedures are performed and paid under Medicare's Hospital Outpatient Comprehensive APC system. To qualify, claims with certain code combinations must meet specific thresholds for both cost and frequency. When these thresholds are met, the code combinations qualify for reassignment to the next highest paying APC.
Comprehensive APC	†	Under its comprehensive APC (C-APC) policy, CMS makes payment for certain costly primary services and all other items and services reported on the hospital outpatient department claim, which CMS considers integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a complete comprehensive service.
Device intensive[11]	¶	Definition/symbol - The "device intensive" status is assigned to all surgical procedures with an individual HCPCS code-level device offset of greater than 40%. Device intensive procedures are identified in Addendum AA with a payment indicator of XX.
Inpatient only (IPO) list		CMS can define procedures and services for which payment under the outpatient prospective payment system (OPPS) is inappropriate. These codes have a status indicator of "C". Services designated as "inpatient only" are not appropriate to be furnished in a hospital outpatient department. Generally, inpatient only procedures are surgical services that require inpatient care because of the nature of the procedure
Modifiers[12]	‖	Modifiers are used to supplement the information or adjust the care description to provide extra details concerning a procedure or service. Modifiers help further describe a procedure code without changing its definition. Modifiers are appended to CPT®[1] codes. List of modifiers can be found in the CPT®[1] book.
Multiple endoscopy rule[13] **Multiple procedure discount[14]**	††	The multiple endoscopy rule applies if an endoscopic procedure code with an indicator "3" on the Medicare Physician Fee Schedule is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). When an ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, Medicare will pay 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures
Packaged payment	§	Under OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.
Payment indicator		CMS uses payment indicators to identify each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services' costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment (72 FR 67189-67190).
Status indicator		In the Hospital Outpatient, Status Indicator (SI) shows how a code is handled for payment purposes: C= Inpatient procedures, not paid under OPPS; J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; S = procedure or service not discounted when multiple procedure; Additional details can be found in Addendum D1 of the OPPS rule
Unlisted codes		Unlisted codes do not have established RVUs under Medicare's Physician Payment System and are typically priced by the contractor after review and individual consideration. Unlisted CPT®[1] codes do not carry a rate assignment from Medicare in the physician office setting. Payment may be available on a case-by-case basis with submission of medical records.
Work relative value unit (RVU)		The Work RVU is a unit of measure that describes the work associated with a physician's procedural services and is factored into the total physician payment. Work RVU is one of three total components on which physician payment is based: physician work RVU, practice expense RVU, and medical malpractice RVU.[7]
w/MCC, w/CC or w/o CC/MCC		In the inpatient setting, w/MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs w/MCC have at least one major secondary complication or comorbidity. Similarly, w/CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs w/CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs w/o CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.

Resources

C-code Finder

Medtronic Reimbursement Support is available to assist you with your coding and reimbursement questions. If your coding or reimbursement questions were not answered in this guide, please check out these additional resources:

Visit our website: https://www.medtronic.com/covidien/en-us/support/reimbursement.html

Email us: rs.MedtronicMedicalSurgicalReimbursement@medtronic.com

Ask us about our Bronchoscopy Report

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