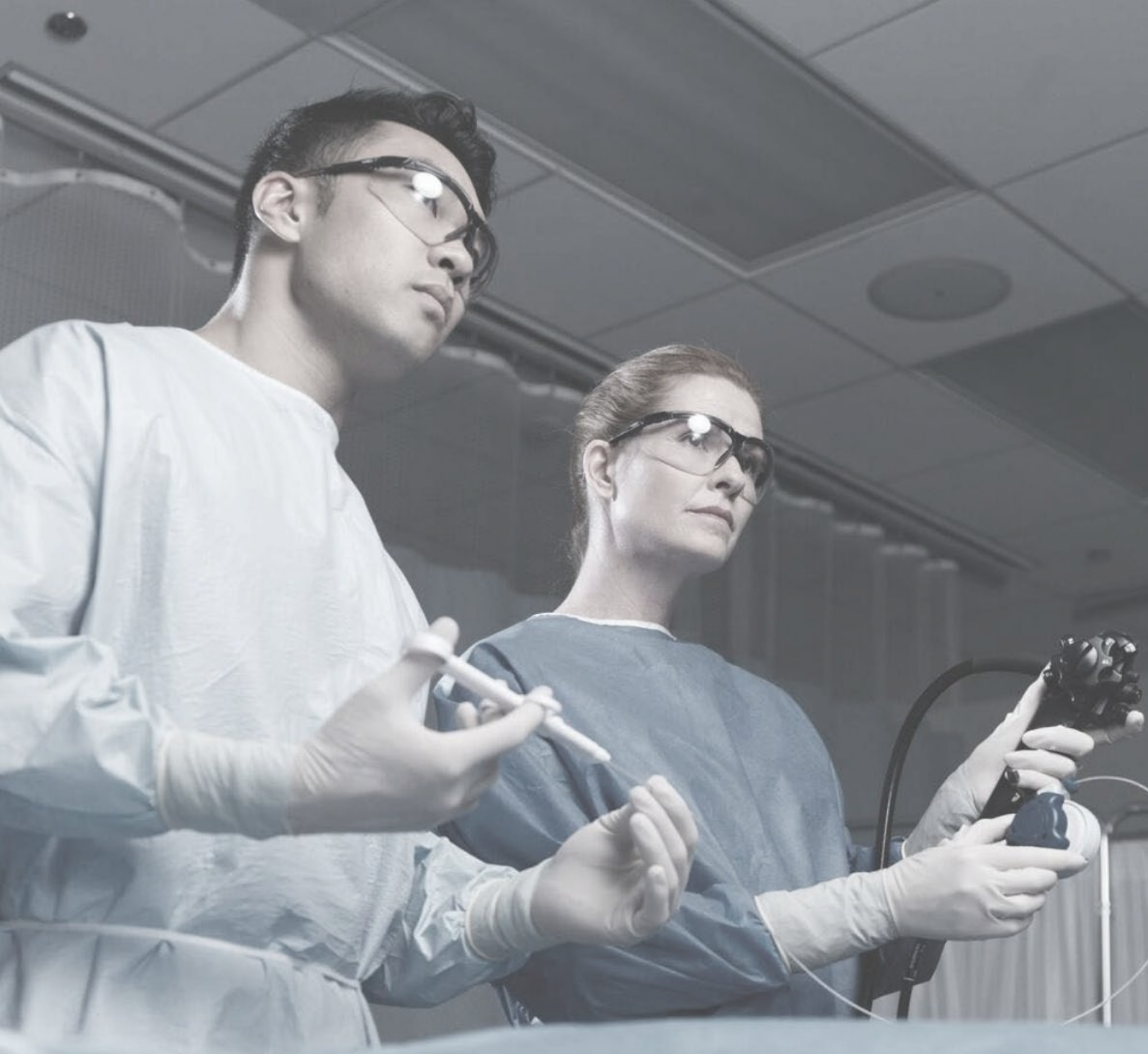

Endoscopy
2024 Procedural Payment Guide

INSIDE THIS GUIDE

- Hospital Inpatient Codes and Payments
- Outpatient Codes and Payments (Hospital, ASC)
- Physician Payment and RVUs

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Introduction

This procedural reimbursement guide, for select endoscopy procedures, provides coding and reimbursement information for physicians and facilities. The Medicare payment amounts shown are national average payments. Actual reimbursement will vary for each provider and institution based on geographic differences in costs, hospital teaching status, and the proportion of low-income patients.

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. The following codes are thought to be relevant to endoscopy procedures and are referenced throughout this guide.

Description of Payment Methods

Physician Billing and Payment: Medicare and other insurers reimburse physicians based on fee schedules tied to CPT® codes. CPT Codes are published by the American Medical Association and are used to report medical services and procedures performed by or under the direction of physicians.[1]

Hospital Outpatient Billing and Payment: Medicare reimburses hospitals for outpatient stays (typically stays of less than 24 hours) under Ambulatory Payment Classification Groups (APCs). Medicare assigns a procedure to an APC based on the billed CPT Code(s). Hospitals may receive separate APC payments for each procedure done during the same outpatient visit. Many APCs are subject to reduced payment when multiple procedures are performed on the same day. In most cases, the highest-valued procedure is paid at 100% and all other procedures are subject to a 50% payment reduction.†

In 2014, CMS implemented their Comprehensive APCs (C-APCs) policy with the goal of identifying certain high-cost device-related outpatient procedures (formerly “device intensive” APCs). CMS has fully implemented this policy and has identified these high-cost, device-related services as the primary service on a claim. All other services reported on the same date will be considered “adjunctive, supportive, related or dependent services” provided to support the delivery of the primary service and will be unconditionally packaged into the OPPS C-APC payment of the primary service with minor exceptions. Only select APCs are impacted. Procedures that are impacted are flagged (†) throughout the guide.†

Hospital Inpatient Billing and Payment: Medicare reimburses hospital inpatient procedures based on the Medicare Severity Diagnosis Related Group (MS-DRG). The MS-DRG is a system of classifying patients based on their diagnoses and the procedures performed during their hospital stay. MS-DRGs closely calibrate payment to the severity of a patient’s illness. One single MS-DRG payment is intended to cover all hospital costs associated with treating an individual during his or her hospital stay, except for “professional” (e.g., physician charges associated with performing medical procedures). Private payers may also use MS-DRG based systems or other payer-specific systems to pay hospitals for providing inpatient services. Effective October 1, 2013, Medicare implemented two-midnight stay guidance. Inpatient admittance is presumed to be appropriate if a physician expects a beneficiary’s surgical procedure, diagnostic test, or other treatment to require a stay in the hospital lasting at least two midnights and admits the beneficiary to the hospital based on that expectation. Documentation in the medical record must support a reasonable expectation of the need for the beneficiary to require a medically necessary stay lasting at least two midnights. If the inpatient admission lasts fewer than two midnights due to an unforeseen circumstance this also must be clearly documented in the medical record.[4]

Free-Standing Clinic/Ambulatory Surgical Center Billing and Payment: Many procedures are performed outside of the hospital in free-standing clinics. Payments made to free-standing clinics from private insurers depend on the contract the clinic has with the payer. Medicare payments to free-standing clinics are determined in part, by the licensing status of the clinic. If a free-standing clinic is licensed by Medicare as an Ambulatory Surgical Center (ASC) it is eligible to be reimbursed for select procedures provided in this setting. Not all procedures that Medicare covers in the hospital setting are eligible for payment in ASCs. Medicare has approved over 4,000 procedures (as defined by CPT Code), for which it will pay the ASC a facility fee.[NA,3]

Important Information

The codes included in this guide are intended to represent typical endoscopy procedures where there is:

1) At least one device approved or cleared by the U.S. Food and Drug Administration (FDA) for use in the listed procedure; and
2) Specific procedural coding guidance provided by a recognized coding or reimbursement authority such as the American Medical Association (AMA) or The Centers for Medicare and Medicaid Services (CMS). This guide is in no way intended to promote the off-label use of medical devices.

The Medicare reimbursement amounts shown are current published national average payments.

Actual reimbursement will vary for each provider and institution for a variety of reasons including geographic differences in labor and non-labor costs, hospital teaching status, and/or proportion of low-income patients. On average, private payers pay more than Medicare.[7]

Please feel free to contact the Boston Scientific Endoscopy Reimbursement Help Desk at 508.683.4510 or at ENDOreimbursement@bsci.com if you have any questions.

You can find reimbursement updates on our website: WWW.BOSTONSCIENTIFIC.COM/REIMBURSEMENT

Disclaimers

Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on the medically appropriate needs of that patient and the independent medical judgment of the HCP.

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered. It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label.

How to Interpret This Guide

1 Ambulatory Payment Classification (APC)[8]: CMS sets hospital outpatient reimbursement rates using the Ambulatory Payment Classifications (APCs), a package of services with equivalent clinical factors and costs. Each APC is assigned a scaled relative payment weight based on the average costs for the services included in the package.

			RVUs			Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Diagnostic									
5303†	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	9.50	NA	$316	NA	$3,649	$1,799

2 CPT Code and Code Description [8]: The Current Procedural Terminology (CPT®) codes offer doctors and health care professionals a uniform language for coding medical services and procedures to streamline reporting, increase accuracy and efficiency. CPT codes are also used for administrative management purposes such as claims processing and developing guidelines for medical care review.

			RVUs			Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Diagnostic									
5303†	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	9.50	NA	$316	NA	$3,649	$1,799

3 RVUs[9]: RVUs are the basic component of the Resource-Based Relative Value Scale (RBRVS), used by CMS and private payers to determine physician payment. RVUs define the value of a service or procedure relative to all services and procedures.

			RVUs			Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Diagnostic									
5303†	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	9.50	NA	$316	NA	$3,649	$1,799

4 Physician Payment[9]: The physician payment is calculated using the Total Office or Total Facility RVU multiplied by an annual dollar conversion factor (CF). Non-facility usually refers to the physician's office. Facility can refer to an inpatient hospital, ambulatory surgery center, or skilled nursing facility.

			RVUs			Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Diagnostic									
5303†	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	9.50	NA	$316	NA	$3,649	$1,799

5 Facility Payment[10]:

- Hospital Outpatient Payment: Based on CMS' Outpatient Prospective Payment System (OPPS). CMS determines the payment rate for each service by multiplying the current years relative weight for the service's APC by a wage-adjusted conversion factor.
- Ambulatory Surgery Center (ASC): The ASC payment system sets payments for procedures using a set of relative weights, a conversion factor (or base payment amount), and adjustments for geographic differences in input prices. However, the conversion factor used in the ASC payment system is approximately 60% of that used in the OPPS.

			RVUs			Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Diagnostic									
5303†	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	9.50	NA	$316	NA	$3,649	$1,799

U.S. Coding & Payment by Site of Service

The Where, What and Why of Reimbursement

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		Hospital Inpatient	Hospital Outpatient	Ambulatory Surgical Center	Physician's office
Procedure Code ("What" was done)	MD	**CPT® Code/HCPCS** Current Procedural Terminology (CPT)/Healthcare Current Procedural Coding System (HCPCS a.k.a. "hikpiks") Published respectively by: American Medical Association (AMA)/Centers for Medicare & Medicaid Services (CMS)			
	Facility	**ICD-10-PCS Procedure Codes**	**CPT Code/HCPCS**		**See Office Differential below**
Diagnosis Code ("Why" it was done)	MD	**ICD-10-CM** *International Classification of Diseases* Published by: World Health Organization (WHO) Clinically modified for use in the USA by CMS			
	Facility				
Payment	MD	**Resource-Based Relative Value System (RBRVS)** Controlled by CMS with input from AMA's RUC Committee (Each CPT Code is assigned Relative Value Units - RVUs) Used by Medicare and most Private Payers (Private rates vary widely by site of service; see below for more information.)			
	Facility	**Medicare MS-DRGs** (Medicare Severity Diagnosis Related Groups) MS-DRGs are derived from ICD-10 Diagnosis & ICD-10 Procedure codes. They pay the hospital a lump sum per admission. Many Private Payers use DRGs but others use per-diems, case rates, and percent of charges. On average, private payers reimburse at 137- 231% of Medicare rates for inpatient services.[11,12]	**Medicare OPPS APCs** (Ambulatory Payment Classifications) APCs are groupings of similar CPT codes paying a single rate. Private Payers use a variety of mechanisms (some use APCs) to pay hospitals for their outpatient facility costs. On average, private payers reimburse at 155 - 293% of Medicare rates for outpatient services.[12]	**ASC Rates** Medicare ASC rates are calculated annually as a percent of the corresponding hospital outpatient OPPS APC payment rate (61% for 2023). Medicare applies additional payment methodologies for procedures identified as "device-intensive" with a device offset of greater than 40%. Private payers tend to follow Medicare's lead in the ASC.	**Office Differential** There is no facility fee per se in the MD Office. There is an office-based (aka Non-Facility Based) differential for some procedure codes paid by Medicare and some private payers to compensate for the higher practice expense of office-based services. On average, private payers reimburse at 117% - 179% of Medicare rates for physician specialist services.[12]

Gastroenterology

Biliary and Cholangioscopy Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Biliary Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility3	
APC	CPT® Code1	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Diagnostic									
5303†	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	9.50	NA	$316	NA	$3,649	$1,799
Therapeutic									
5303†	43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	9.97	NA	$332	NA	$3,649	$1,799
5303†	43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	6.50	10.50	NA	$350	NA	$3,649	$1,799
5302†	43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	6.50	10.52	NA	$350	NA	$1,813	$832
5303†	43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	6.63	10.71	NA	$357	NA	$3,649	$1,799
5331†	43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (e.g., mechanical, electrohydraulic, lithotripsy)	7.93	12.74	NA	$424	NA	$5,430	$2,575
5303†	43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct	6.90	11.13	NA	$370	NA	$3,649	$1,799
5303†	43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed	7.92	12.74	NA	$424	NA	$3,649	$1,799
Stenting									
5331†,±	43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	8.48	13.61	NA	$453	NA	$5,430	$3,319
5302†	43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	6.86	11.07	NA	$368	NA	$1,813	$832
5331†,±	43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	8.84	14.17	NA	$472	NA	$5,430	$3,323

Cholangioscopy Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility3	
APC	CPT® Code1	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Cholangioscopy									
NA	+43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/ common bile duct(s) (List separately in addition to code(s) for primary procedure	2.24	3.50	NA	$117	NA	$0	$0

CPT Code 43273 is an Add-on code and must be reported with at least one of the above ERCP codes.

Medicare Hospital Inpatient Coding for Biliary and Cholangioscopy - Select Procedures

*Specific to the use of Single-Use Duodenoscopes such as EXALT™ Model D.

ICD-10 PCS Code	ICD-10 PCS Description
XFJB8A7*	Inspection of hepatobiliary duct using single use duodenoscope
XFJD8A7*	Inspection of pancreatic duct using single use duodenoscope
0F558ZZ	Destruction of Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F568ZZ	Destruction of Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F578ZZ	Destruction of Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F588ZZ	Destruction of Cystic Duct, Via Natural or Artificial Opening Endoscopic
0F598ZZ	Destruction of Common Bile Duct, Endoscopic
0F5C8ZZ	Destruction of Ampulla of Vater, Endoscopic
0F5D8ZZ	Destruction of Pancreatic Duct, Endoscopic
0F5F8ZZ	Destruction of Accessory Pancreatic Duct, Via Natural or Artificial Opening Endoscopic

Biliary and Cholangioscopy Procedural Reimbursement Guide (continued)

Medicare Hospital Inpatient Coding for Biliary and Cholangioscopy - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0F758DZ	Dilation of Right Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F758ZZ	Dilation of Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F768DZ	Dilation of Left Hepatic Duct with Intraluminal Device, Endoscopic
0F768ZZ	Dilation of Left Hepatic Duct, Endoscopic
0F778DZ	Dilation of Common Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F778ZZ	Dilation of Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F788DZ	Dilation of Cystic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F788ZZ	Dilation of Cystic Duct, Endoscopic
0F798DZ	Dilation of Common Bile Duct with Intraluminal Device, Endoscopic
0F798ZZ	Dilation of Common Bile Duct, Endoscopic
0F7C8DZ	Dilation of Ampulla of Vater with Intraluminal Device, Endoscopic
0F7C8ZZ	Dilation of Ampulla of Vater, Endoscopic
0F7D8DZ	Dilation of Pancreatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F7D8ZZ	Dilation of Pancreatic Duct, Endoscopic
0F7F8DZ	Dilation of Accessory Pancreatic Duct with Intraluminal Device, Endoscopic
0F7F8ZZ	Dilation of Accessory Pancreatic Duct, Endoscopic
0FB98ZX	Excision of Common Bile Duct, Endoscopic, Diagnostic
0FBC8ZX	Excision of Ampulla of Vater, Endoscopic, Diagnostic
0FBD8ZX	Excision of Pancreatic Duct, Endoscopic, Diagnostic
0FBF8ZX	Excision of Accessory Pancreatic Duct, Via Natural or Artificial Opening Endoscopic, Diagnostic
0FC58ZZ	Extirpation of Matter from Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC68ZZ	Extirpation of Matter from Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC78ZZ	Extirpation of Matter from Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC98ZZ	Extirpation of Matter from Common Bile Duct, Endoscopic
0FCD8ZZ	Extirpation of Matter from Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FCF8ZZ	Extirpation of Matter from Accessory Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FF58ZZ	Fragmentation in Right Hepatic Duct, Endoscopic
0FF68ZZ	Fragmentation in Left Hepatic Duct, Endoscopic
0FF78ZZ	Fragmentation in Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FF88ZZ	Fragmentation in Cystic Duct, Via Natural or Artificial Opening Endoscopic
0FF98ZZ	Fragmentation in Common Bile Duct, Endoscopic
0FFC8ZZ	Fragmentation in Ampulla of Vater, Endoscopic
0FFD8ZZ	Fragmentation in Pancreatic Duct, Endoscopic
0FFF8ZZ	Fragmentation in Accessory Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FHB8DZ	Insertion of Intraluminal Device into Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0FHD8DZ	Insertion of Intraluminal Device into Pancreatic Duct, Endoscopic
0FJB8ZZ	Inspection of Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0FJD8ZZ	Inspection of Pancreatic Duct, Endoscopic
0FPB80Z	Removal of Drainage Device from Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0FPB8DZ	Removal of Intraluminal Device from Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0FPD80Z	Removal of Drainage Device from Pancreatic Duct, Endoscopic
0FPD8DZ	Removal of Intraluminal Device from Pancreatic Duct, Endoscopic

Biliary and Cholangioscopy Procedural Reimbursement Guide (continued)

Medicare Hospital Inpatient Payment

MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

MS-DRG	Description	Inpatient Hospital Medicare National Average Payment[4]
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC[6])	$12,322
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC[6])	$7,707
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,819
438	Disorders of pancreas except malignancy with MCC[6]	$11,684
439	Disorders of pancreas except malignancy with CC[6]	$5,988
440	Disorders of pancreas except malignancy without CC/MCC	$4,310
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC[6]	$12,800
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC[6]	$6,662
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$5,004
444	Disorders of the biliary tract with MCC[6]	$11,435
445	Disorders of the biliary tract with CC[6]	$7,609
446	Disorders of the biliary tract without CC/MCC	$5,612

Biopsy Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Cold Biopsy									
5302†	43193	Esophagoscopy, rigid, transoral; with biopsy, single or multiple	2.79	5.07	NA	$169	NA	$1,813	$832
5302†	43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	1.72	3.06	10.66	$102	$355	$1,813	$832
5301	43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	2.39	4.10	11.28	$136	$375	$864	$470
5303†	43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	9.97	NA	$332	NA	$3,649	$1,799
5302†	44361	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple	2.77	4.68	NA	$156	NA	$1,813	$832
5302†	44377	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple	5.42	8.81	NA	$293	NA	$1,813	$832
5301	44382	Ileoscopy, through stoma; with biopsy, single or multiple	1.17	2.20	8.93	$73	$297	$864	$470
5311	44386	Endoscopic evaluation of small intestinal pouch (e.g., Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple	1.50	2.65	9.30	$88	$310	$871	$474
5312	44389	Colonoscopy through stoma; with biopsy, single or multiple	3.02	5.07	12.33	$169	$410	$1,124	$612
5312†	45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	1.15	2.18	5.44	$73	$181	$1,124	$612
5311	45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	1.14	2.15	8.58	$72	$286	$871	$474
5312	45380	Colonoscopy, flexible; with biopsy, single or multiple	3.56	5.92	12.99	$197	$432	$1,124	$612
Hot Biopsy									
5302†	43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.30	3.95	12.22	$131	$407	$1,813	$832
5302†	43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.97	5.03	13.45	$167	$448	$1,813	$832
5302†	44365	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.21	5.38	NA	$179	NA	$1,813	$832
5312	44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	3.53	5.91	11.68	$197	$389	$1,124	$612
5313†	45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1.30	2.54	6.14	$85	$204	$2,675	$1,349
5311	45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	1.55	2.80	9.83	$93	$327	$871	$474
5312	45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.07	6.74	14.62	$224	$487	$1,124	$612

Hospital Inpatient Coding and Medicare Payment

Inpatient payment information is not shown because biopsy procedures will rarely, if ever, be the primary reason for a hospital admission.

Dilation Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Balloon									
5303†	43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)	3.07	5.54	NA	$184	NA	$3,649	$1,799
5302†	43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	3.40	5.75	NA	$191	NA	$1,813	$832
5302†	43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)	2.00	3.50	26.69	$117	$888	$1,813	$832
5302†	43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	4.07	6.77	NA	$225	NA	$1,813	$832
5302†	43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.67	4.54	32.04	$151	$1,067	$1,813	$832
5302†	44381	Ileoscopy, through stoma; with transendoscopic balloon dilation	1.38	2.52	29.13	$84	$970	$1,813	$832
5312†±	44405	Colonoscopy through stoma; with transendoscopic balloon dilation	3.23	5.41	16.59	$180	$552	$1,124	$612
5312	45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	1.25	2.33	13.61	$78	$453	$1,124	$612
5312	45386	Colonoscopy, flexible; with transendoscopic balloon dilation	3.77	6.25	18.20	$208	$606	$1,124	$612
Balloon or Rigid									
5302†	43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire	3.31	5.86	NA	$195	NA	$1,813	$832
5302†	43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	4.63	7.68	36.37	$256	$1,211	$1,813	$832
5302†	43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire	2.24	3.87	11.55	$129	$384	$1,813	$832
5302†	43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (e.g., balloon, bougie)	3.08	5.19	17.72	$173	$590	$1,813	$832
5301	43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	2.91	4.91	12.38	$163	$412	$864	$470
5312	45303	Proctosigmoidoscopy, rigid; with dilation (e.g., balloon, guide wire, bougie)	1.40	2.56	28.07	$85	$934	$1,124	$612

Hospital Inpatient Coding and Medicare Payment

Inpatient payment information not shown because dilation procedures will rarely, if ever, be the primary reason for a hospital admission.

Endoluminal Surgery Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Endoscopic Mucosal Resection (EMR)

Medicare Physician, Hospital Outpatient, and ASC Payments

				RVUs		2024 Medicare National Average Payment Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
EMR									
5302†	43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	4.20	6.92	NA	$230	NA	$1,813	$832
5302†	43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	4.87	7.95	NA	$265	NA	$1,813	$832
5312	44403	Colonoscopy through stoma; with endoscopic mucosal resection	5.50	8.96	NA	$298	NA	$1,124	$612
5313†	45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	3.52	5.84	NA	$194	NA	$2,675	$1,349
5313†	45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.04	9.79	NA	$326	NA	$2,675	$1,349

Endoscopic Submucosal Dissection (ESD)

Medicare Hospital Outpatient Payment

The Centers for Medicare & Medicaid Services (CMS) has established a new HCPCS Code describing the Endoscopic Submucosal Dissection (ESD) procedure during an endoscopy or colonoscopy. Effective October 1, 2021, HCPCS Code C9779 may be used by hospitals to report ESD procedures performed in the outpatient setting.

APC	HCPCS Code	Description	2024 Medicare National Average Payment[3]
5303†	C9779	Endoscopic submucosal dissection (ESD), including endoscopy or colonoscopy, mucosal closure, when performed	$3,649

ESD Medicare Physician Coding & Payment

Currently, there is no unique Current Procedural Terminology (CPT) codes for ESD. In the absence of a unique ESD code, physicians may bill an unlisted procedure code. Physicians should submit a cover letter with the claim that explains the nature of the procedure, equipment required, estimated practice cost, and a comparison of physician work (time, intensity, risk) with other comparable services for which the payer has an established value.

Reimbursement information is being provided for illustrative purposes only. Providers are solely responsible for all procedure, coding, and billing decisions.

				RVUs		2024 Medicare National Average Payment Physician‡, 2	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office
ESD							
5301	43499	Unlisted procedure, esophagus	NA	NA	NA	NA	NA
5301	43999	Unlisted procedure, stomach	NA	NA	NA	NA	NA
5301	44799	Unlisted procedure, small intestine	NA	NA	NA	NA	NA
5301	45399	Unlisted procedure, colon	NA	NA	NA	NA	NA
5301	45999	Unlisted procedure, rectum	NA	NA	NA	NA	NA

Peroral Endoscopic Myotomy (POEM)

Medicare Physician and Hospital Outpatient Payments

The American Medical Association (AMA) has established a new CPT Code describing the Peroral Endoscopic Myotomy (POEM) procedure. CPT Code 43497 may be used to report POEM procedures.

				RVUs		2024 Medicare National Average Payment Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
POEM									
5331†	43497	Lower esophageal myotomy, transoral (i.e., Peroral endoscopic myotomy [POEM])	13.29	23.49	NA	$782	NA	$5,430	N/A

Endoscopic Closure

Currently, there is no unique Current Procedural Terminology (CPT) codes for Endoscopic Closure. In the absence of a unique code, providers may bill an unlisted procedure code. For closure of a perforation, fistula or leaks, it would be an unlisted procedure code for the area in which closure is performed. Average payments for unlisted procedure codes reflect payment for all unlisted procedures.

Endoscopic Ultrasound-Guided Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Upper Gastrointestinal Procedures									
5302†	43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	3.59	5.87	NA	$195	NA	$1,813	$832
5302†	43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)	4.16	6.84	NA	$228	NA	$1,813	$832
5302†	43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	4.73	7.74	NA	$258	NA	$1,813	$832
5302†	43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	2.96	4.97	10.18	$165	$339	$1,813	$832
5302†	43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (e.g., anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	4.73	7.73	NA	$257	NA	$1,813	$832
Lower Gastrointestinal Procedures									
5312	44407	Coloscopy through stoma; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	4.96	8.10	NA	$270	NA	$1,124	$612
5312	45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	2.98	5.04	NA	$168	NA	$1,124	$612
5312	45392	Colonoscopy, flexible; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse or ascending colon and cecum, and adjacent structures	5.50	8.96	NA	$298	NA	$1,124	$612

Hospital Inpatient Coding and Medicare Payment

Inpatient payment information not shown because endoscopic ultrasound-guided procedures will rarely, if ever, be the primary reason for a hospital admission.

Enteral Feeding Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Gastrostomy Tube Initial Placement									
5302†	43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	3.56	5.92	NA	$197	NA	$1,813	$832
5302†	49440	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.93	5.93	24.48	$197	$815	$1,813	$832
Gastrostomy Tube Replacement/Reposition									
5371	43761	Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition	2.01	3.09	3.70	$103	$123	$235	$128
5371	43762	Replacement of gastrostomy tube, with no revision	0.75	1.11	6.76	$37	$225	$235	$128
5371	43763	Replacement of gastrostomy tube, with revision	1.41	2.61	10.00	$87	$333	$235	$128
5301	49450	Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	1.36	1.91	17.52	$64	$583	$864	$470
Duodenostomy or Jejunostomy Tube									
5302†	44373	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube	3.39	5.64	NA	$188	NA	$1,813	$832
5302†	49441	Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	4.52	7.07	28.33	$235	$943	$1,813	$832
5302†	49446	Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.06	4.26	23.51	$142	$783	$1,813	$832
5301	49452	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	2.86	3.97	22.74	$132	$757	$864	$470
Other Procedures									
5301	49460	Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation and report	0.96	1.49	21.57	$50	$718	$864	$470

Hospital Inpatient Coding and Medicare Payment

Inpatient payment information not shown because enteral feeding procedures will rarely, if ever, be the primary reason for a hospital admission.

Hemostasis/Clipping Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Control of Bleeding									
5302†	43227	Esophagoscopy, flexible, transoral; with control of bleeding, any method	2.89	4.88	17.74	$162	$591	$1,813	$832
5302†	43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	3.56	5.90	18.68	$196	$622	$1,813	$832
5302†	44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)6	4.30	7.06	NA	$235	NA	$1,813	$832
5302†	44378	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)[5]	7.02	11.31	NA	$376	NA	$1,813	$832
5312	44391	Colonoscopy through stoma; with control of bleeding, any method	4.12	6.80	19.08	$226	$635	$1,124	$612
5312	45334	Sigmoidoscopy, flexible; with control of bleeding, any method	2.00	3.48	14.68	$116	$489	$1,124	$612
5312	45382	Colonoscopy, flexible; with control of bleeding, any method	4.66	7.62	19.86	$254	$661	$1,124	$612
Ligation									
5302†	43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices	2.44	4.17	NA	$139	NA	$1,813	$832
5302†	43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	4.40	7.22	NA	$240	NA	$1,813	$832
5312	45350	Sigmoidoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)	1.68	3.00	19.98	$100	$665	$1,124	$612
5312	45398	Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids)	4.20	6.95	24.52	$231	$816	$1,124	$612
5311	46221	Hemorrhoidectomy, internal, by rubber band ligation(s)	2.36	5.80	8.53	$193	$284	$871	$191
Injection									
5302†	43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	2.79	5.09	NA	$169	NA	$1,813	$832
5302†	43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	1.72	3.08	7.79	$103	$259	$1,813	$832
5302†	43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices	2.33	3.99	NA	$133	NA	$1,813	$832
5301	43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	2.39	4.10	12.02	$136	$400	$864	$470
5302†	43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices	4.27	7.01	NA	$233	NA	$1,813	$832
5312	44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	3.02	5.07	12.60	$169	$419	$1,124	$612
5311	45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	1.04	1.99	8.71	$66	$290	$871	$474
5312	45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	3.56	5.91	13.26	$197	$441	$1,124	$612

Clipping

Endoscopic Marking

There are no specific CPT® Codes for endoscopic tissue marking with a clip; the procedure defaults to an unlisted procedure code for the area in which the clip is being placed (e.g., unlisted procedure code for the intestine: 44799). Average payments for unlisted procedure codes reflect payment for all unlisted procedures. They would not accurately represent endoscopic marking procedure payments and therefore are not listed.

Closure

If a clip is used as a method of closure secondary to another procedure then it would be considered inherent in the primary procedure. If the clip is used during a separate event (session) then, it is separately billable. For control of bleeding from a previous polypectomy site, the application of the clip would be considered control of bleeding for the area in which the clip was placed. For closure of a perforation, the application of the clip would be an unlisted procedure code for the area in which the clip is placed. Average payments for unlisted procedure codes reflect payment for all unlisted procedures. It would not be an accurate representation of closure procedure payment and therefore is not listed.

Anchoring of Jejunal Feeding Tube

There is no separate coding for use of the clip; clip placement would be inherent in the primary procedure coding for attachment of the tube (see codes in the “Enteral Feeding Coding and Payment Quick Reference Guide”).

Hemostasis/Clipping Procedural Reimbursement Guide (continued)

Medicare Hospital Inpatient Payment

MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

MS-DRG	Description	Inpatient Hospital Medicare National Average Payment[4]
377	GI hemorrhage with MCC[6]	$12,535
378	GI hemorrhage with CC[6]	$6,888
379	GI hemorrhage without CC/MCC[6]	$4,433
432	Cirrhosis & alcoholic hepatitis with MCC[6]	$13,415
433	Cirrhosis & alcoholic hepatitis with CC[6]	$7,219
434	Cirrhosis & alcoholic hepatitis without CC/MCC	$4,688

Polypectomy Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician[‡, 2]		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Hot Biopsy									
5302†	43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.30	3.95	12.22	$131	$407	$1,813	$832
5302†	43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.97	5.03	13.45	$167	$448	$1,813	$832
5302†	44365	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.21	5.38	NA	$179	NA	$1,813	$832
5312	44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	3.53	5.91	11.68	$197	$389	$1,124	$612
5313†	45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1.30	2.54	6.14	$85	$204	$2,675	$1,349
5311	45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	1.55	2.80	9.83	$93	$327	$871	$474
5312	45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.07	6.74	14.62	$224	$487	$1,124	$612
Snare									
5302†	43217	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.80	4.73	12.59	$157	$419	$1,813	$832
5302†	43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.47	5.78	14.79	$192	$492	$1,813	$832
5302†	44364	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.63	6.02	NA	$200	NA	$1,813	$832
5312	44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.03	6.65	13.13	$221	$437	$1,124	$612
5312	45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	1.40	2.69	6.33	$90	$211	$1,124	$612
5312	45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.05	3.56	8.97	$119	$299	$1,124	$612
5312	45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.57	7.49	13.60	$249	$453	$1,124	$612
Hot Biopsy or Snare									
5312	45315	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery, or snare technique	1.70	3.17	6.83	$106	$227	$1,124	$612
Other									
5303†,±	43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	3.49	5.81	21.16	$193	$704	$3,649	$2,644
Foreign Body Removal									
5302†	43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)	3.51	5.68	NA	$189	NA	$1,813	$832
5302†	43215	Esophagoscopy, flexible, transoral; with removal of foreign body(s)	2.44	4.19	11.75	$139	$391	$1,813	$832
5301	43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	5.22	11.49	$174	$382	$864	$470
5302†	44363	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body(s)	3.39	5.65	NA	$188	NA	$1,813	$832
5313†	45307	Proctosigmoidoscopy, rigid; with removal of foreign body	1.60	3.01	6.41	$100	$213	$2,675	$1,349
5312	45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	1.76	3.13	8.32	$104	$277	$1,124	$612
5312	45379	Colonoscopy, flexible; with removal of foreign body(s)	4.28	7.03	13.01	$234	$433	$1,124	$612
Endoscopic Mucosal Resection									
5302†	43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	4.20	6.92	NA	$230	NA	$1,813	$832
5302†	43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	4.87	7.95	NA	$265	NA	$1,813	$832
5312	44403	Colonoscopy through stoma; with endoscopic mucosal resection	5.50	8.96	NA	$298	NA	$1,124	$612
5313†	45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	3.52	5.84	NA	$194	NA	$2,675	$1,349
5313†	45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.04	9.79	NA	$326	NA	$2,675	$1,349

Hospital Inpatient Coding and Medicare Payment

Inpatient payment information not shown because polypectomy procedures will rarely, if ever, be the primary reason for a hospital admission.

Stenting Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician[‡, 2]		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Biliary Stenting									
5331[†,±]	43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	8.48	13.61	NA	$453	NA	$5,430	$3,319
5302[†]	43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	6.86	11.07	NA	$368	NA	$1,813	$832
5331[†,±]	43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	8.84	14.17	NA	$472	NA	$5,430	$3,323
Esophageal Stenting									
5331[†,±]	43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.40	5.58	NA	$186	NA	$5,430	$3,839
5331[†,±]	43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.92	6.42	NA	$214	NA	$5,430	$3,963
Colonic and Duodenal Stenting									
5331[†,±]	44370	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes pre-dilation)	4.69	7.87	NA	$262	NA	$5,430	$4,334
5331[†]	44379	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes pre-dilation)	7.36	12.06	NA	$401	NA	$5,430	$2,575
5302[†±]	44384	Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	2.85	4.50	NA	$150	NA	$1,813	$1,091
5331[†,±]	44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)	4.70	7.70	NA	$256	NA	$5,430	$3,243
5331[†,±]	45327	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes pre-dilation)	1.90	3.50	NA	$117	NA	$5,430	$3,996
5331[†,±]	45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	2.72	4.55	NA	$151	NA	$5,430	$4,016
5331[†,±]	45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	5.24	8.53	NA	$284	NA	$5,430	$3,946
Foreign Body Removal (Stent Removal)									
5302[†]	43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)	3.51	5.68	NA	$189	NA	$1,813	$832
5302[†]	43215	Esophagoscopy, flexible, transoral; with removal of foreign body(s)	2.44	4.19	11.75	$139	$391	$1,813	$832
5301	43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	5.22	11.49	$174	$382	$864	$470
5302[†]	43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	6.86	11.07	NA	$368	NA	$1,813	$832
5302[†]	44363	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body(s)	3.39	5.65	NA	$188	NA	$1,813	$832
5313[†]	45307	Proctosigmoidoscopy, rigid; with removal of foreign body	1.60	3.01	6.41	$100	$213	$2,675	$1,349
5312	45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	1.76	3.13	8.32	$104	$277	$1,124	$612
5312	45379	Colonoscopy, flexible; with removal of foreign body(s)	4.28	7.03	13.01	$234	$433	$1,124	$612

Stenting Procedural Reimbursement Guide (continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0F758DZ	Dilation of Right Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F768DZ	Dilation of Left Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F778DZ	Dilation of Common Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F778ZZ	Dilation of Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F788DZ	Dilation of Cystic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F798DZ	Dilation of Common Bile Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F7C8DZ	Dilation of Ampulla of Vater with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F7D8DZ	Dilation of Pancreatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F7F8DZ	Dilation of Accessory Pancreatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0FHB8DZ	Insertion of Intraluminal Device into Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0F7D8DZ	Dilation of Pancreatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F7F8DZ	Dilation of Accessory Pancreatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0FHB8DZ	Insertion of Intraluminal Device into Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0FHD8DZ	Insertion of Intraluminal Device into Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FC58ZZ	Extirpation of Matter from Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC68ZZ	Extirpation of Matter from Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC78ZZ	Extirpation of Matter from Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC88ZZ	Extirpation of Matter from Cystic Duct, Via Natural or Artificial Opening Endoscopic
0FC98ZZ	Extirpation of Matter from Common Bile Duct, Via Natural or Artificial Opening Endoscopic
0FCC8ZZ	Extirpation of Matter from Ampulla of Vater, Via Natural or Artificial Opening Endoscopic
0FCD8ZZ	Extirpation of Matter from Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FCF8ZZ	Extirpation of Matter from Accessory Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FPB8DZ	Removal of Intraluminal Device from Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0FPD8DZ	Removal of Intraluminal Device from Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0D718DZ	Dilation of Upper Esophagus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D728DZ	Dilation of Middle Esophagus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D738DZ	Dilation of Lower Esophagus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D748DZ	Dilation of Esophagogastric Junction with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D758DZ	Dilation of Esophagus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0DH58DZ	Insertion of Intraluminal Device into Esophagus, Via Natural or Artificial Opening Endoscopic
0D768DZ	Dilation of Stomach with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D778DZ	Dilation of Stomach, Pylorus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D798DZ	Dilation of Duodenum with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0DH68DZ	Insertion of Intraluminal Device into Stomach, Via Natural or Artificial Opening Endoscopic
0DH98DZ	Insertion of Intraluminal Device into Duodenum, Via Natural or Artificial Opening Endoscopic
0DH88DZ	Insertion of Intraluminal Device into Small Intestine, Via Natural or Artificial Opening Endoscopic
0DHB8DZ	Insertion of Intraluminal Device into Ileum, Via Natural or Artificial Opening Endoscopic
0DHE8DZ	Insertion of Intraluminal Device into Large Intestine, Via Natural or Artificial Opening Endoscopic
0DHP8DZ	Insertion of Intraluminal Device into Rectum, Via Natural or Artificial Opening Endoscopic
0DC18ZZ	Extirpation of Matter from Upper Esophagus, Via Natural or Artificial Opening Endoscopic
0DC28ZZ	Extirpation of Matter from Middle Esophagus, Via Natural or Artificial Opening Endoscopic
0DC38ZZ	Extirpation of Matter from Lower Esophagus, Via Natural or Artificial Opening Endoscopic
0DC58ZZ	Extirpation of Matter from Esophagus, Via Natural or Artificial Opening Endoscopic
0DC48ZZ	Extirpation of Matter from Esophagogastric Junction, Via Natural or Artificial Opening Endoscopic
0DC68ZZ	Extirpation of Matter from Stomach, Via Natural or Artificial Opening Endoscopic
0DC78ZZ	Extirpation of Matter from Stomach, Pylorus, Via Natural or Artificial Opening Endoscopic
0DC88ZZ	Extirpation of Matter from Small Intestine, Via Natural or Artificial Opening Endoscopic
0DC98ZZ	Extirpation of Matter from Duodenum, Via Natural or Artificial Opening Endoscopic
0DCA8ZZ	Extirpation of Matter from Jejunum, Via Natural or Artificial Opening Endoscopic
0DCN8ZZ	Extirpation of Matter from Sigmoid Colon, Via Natural or Artificial Opening Endoscopic
0DCP8ZZ	Extirpation of Matter from Rectum, Via Natural or Artificial Opening Endoscopic
0DCC8ZZ	Extirpation of Matter from Ileocecal Valve, Via Natural or Artificial Opening Endoscopic
0DCE8ZZ	Extirpation of Matter from Large Intestine, Via Natural or Artificial Opening Endoscopic
0DCF8ZZ	Extirpation of Matter from Right Large Intestine, Via Natural or Artificial Opening Endoscopic
0DCG8ZZ	Extirpation of Matter from Left Large Intestine, Via Natural or Artificial Opening Endoscopic
0DCH8ZZ	Extirpation of Matter from Cecum, Via Natural or Artificial Opening Endoscopic
0DCK8ZZ	Extirpation of Matter from Ascending Colon, Via Natural or Artificial Opening Endoscopic
0DCL8ZZ	Extirpation of Matter from Transverse Colon, Via Natural or Artificial Opening Endoscopic
0DCM8ZZ	Extirpation of Matter from Descending Colon, Via Natural or Artificial Opening Endoscopic

Stenting Procedural Reimbursement Guide (continued)

Medicare Hospital Inpatient Payment

MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

MS-DRG	Description	Inpatient Hospital Medicare National Average Payment[4]
329	Major Small & Large Bowel Procedures with MCC[6]	$31,625
330	Major Small & Large Bowel Procedures with CC[6]	$16,608
331	Major Small & Large Bowel Procedures without CC/MCC	$11,707
374	Digestive Malignancy with MCC[6]	$14,696
375	Digestive Malignancy with CC[6]	$8,390
376	Digestive Malignancy without CC/MCC	$6,241
391	Esophagitis, Gastroenteritis, & Miscellaneous Digest Disorders with MCC[6]	$8,932
392	Esophagitis, Gastroenteritis, & Miscellaneous Digest Disorders without MCC	$5,500
377	GI Hemorrhage with MCC[6]	$12,535
378	GI Hemorrhage with CC[6]	$6,888
379	GI Hemorrhage without CC/MCC	$4,433
405	Pancreas, liver, and shunt procedures with MCC[6]	$38,545
406	Pancreas, liver, and shunt procedures with CC[6]	$20,216
407	Pancreas, liver, and shunt procedures without CC/MCC	$15,060
432	Cirrhosis & alcoholic hepatitis with MCC[6]	$13,415
433	Cirrhosis & alcoholic hepatitis with CC[6]	$7,219
434	Cirrhosis & alcoholic hepatitis without CC/MCC	$4,688
435	Malignancy of hepatobiliary system or pancreas with MCC[6]	$12,322
436	Malignancy of hepatobiliary system or pancreas with CC[6]	$7,707
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,819

Advanced Endoscopic Ultrasound-Guided Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician[‡, 2]		Facility[3]	
APC	CPT® Code	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Pancreatic Pseudocyst Drainage and Stent Placement									
5331[†,‡]	43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)	7.15	11.54	NA	$384	NA	$5,430	$4,025
Stent Retrieval									
5301	43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	5.22	11.49	$174	$382	$864	$470
Gallbladder Drainage and Stent Placement									
5301	47999	Unlisted procedure, biliary tract (includes gallbladder)	NA	NA	NA	NA	NA	$864	N/A
Endoscopic Necrosectomy									
5071	48999	Unlisted procedure, pancreas	NA	NA	NA	NA	NA	$670	N/A

Note: Currently, there is no unique Current Procedural Terminology (CPT) code to describe endoscopic necrosectomy. In the absence of a unique code, providers should bill an unlisted procedure code. Providers should submit a cover letter to the payer with the claim that explains the nature of the procedure, equipment required, estimated practice cost, and a comparison of the physician work (time, intensity, risk) with other comparable services for which the payer has an established value.

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0F9G80Z	Drainage of Pancreas with Drainage Device, Via Natural or Artificial Opening Endoscopic
0FBG8ZZ	Excision of Pancreas, Via Natural or Artificial Opening Endoscopic
0F9480Z	Drainage of Gallbladder with Drainage Device, Via Natural or Artificial Opening Endoscopic

Medicare Hospital Inpatient Payment

MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

MS-DRG	Description	Inpatient Hospital Medicare National Average Payment[4]
Pancreas		
405	Pancreas, liver, and shunt procedures with MCC[6]	$38,545
406	Pancreas, liver, and shunt procedures with CC[6]	$20,216
407	Pancreas, liver, and shunt procedures without CC/MCC	$15,060
438	Disorders of pancreas except malignancy with MCC[6]	$11,684
439	Disorders of pancreas except malignancy with CC[6]	$5,988
440	Disorders of pancreas except malignancy without CC/MCC	$4,310
Gallbladder		
444	Disorders of the biliary tract with MCC[6]	$11,435
445	Disorders of the biliary tract with CC[6]	$7,609
446	Disorders of the biliary tract without CC/MCC	$5,612

Gastroenterology Notes

Endobariatric

Endobariatric Procedural Reimbursement Guide

Endoscopic Sleeve Gastroplasty (ESG) and Transoral Outlet Reduction (TORe)

Medicare Hospital Outpatient Facility Payment

The Centers for Medicare & Medicaid Services (CMS) has established a new HCPCS Code describing the Endoscopic Sleeve Gastroplasty (ESG) and Transoral Outlet Reduction (TORe). Effective July 1, 2023, HCPCS Codes C9784 and C9785 may be used by hospitals to report ESG and TORe procedures performed in the outpatient setting. Medicare does not allow these procedures to be performed in an ASC.

APC	HCPCS Code	Code Description	2024 Medicare National Average Payment[3]
5362†,±	C9784	Gastric restrictive procedure, endoscopic sleeve gastroplasty, with esophagogastroduodenoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	$9,808
5362†,±	C9785	Endoscopic outlet reduction, gastric pouch application, with endoscopy and intraluminal tube insertion, if performed, including all system and tissue anchoring components	$9,808

Medicare Physician Payment

Currently, there is no unique Current Procedural Terminology (CPT) codes for ESG or TORe. In the absence of unique codes, physicians may bill an unlisted procedure code. Physicians should submit a cover letter with the claim that explains the nature of the procedure, equipment required, estimated practice cost, and a comparison of physician work (time, intensity, risk) with other comparable services for which the payer has an established value.

Reimbursement information is being provided for illustrative purposes only. Providers are solely responsible for all procedure, coding, and billing decisions.

			2024 Medicare National Average Payment				
			RVUs			Physician‡, 2	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office
5301	43999	Unlisted procedure, stomach	N/A	N/A	NA	N/A	N/A

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Intragastric Balloon

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

				2024 Medicare National Average Payment						
				RVUs			Physician‡, 2		Facility[3]	
APC	CPT® Code	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Intragastric Balloon Placement										
5302†,±	43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	3.11	5.38	78.00	$179	$2,596	$1,813	$832
Intragastric Balloon Removal										
5301†,±	43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	2.80	4.74	13.76	$158	$458	$864	$470

C-Code Information

C1889	**Implantable/insertable device, not otherwise classified**

For other C-Code information, please reference the C-Code Finder.

Endobariatric Notes

Surgical

Laparoscopic Cholecystectomy with and without Common Bile Duct Exploration (CBDE) Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Laparoscopic Cholecystectomy									
5361†	47562	Laparoscopy, surgical; cholecystectomy	10.47	19.92	NA	$663	NA	$5,498	$2,705
5361†	47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.47	21.65	NA	$721	NA	$5,498	$2,705
5362†	47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	18.00	33.65	NA	$1,120	NA	$9,808	$4,541
Choledochoscopy (Add-on Code)									
NA	+47550	Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)	3.02	4.85	NA	$161	NA	$0	$0

+CPT Code 47550 is an Add-on code and must be reported with a primary procedure. CMS categorizes this code as a "Type II Add-on Code". Type II Add-on codes do not have a defined set of primary procedure codes. CMS indicates primary procedures are "Contractor Defined" and may therefore vary among Medicare Administrative Carriers (MACs) and private payers.

NOTE: CPT Add-on Code +47550 (Choledochoscopy) has been removed from the "*Inpatient Procedures Only List*", *effective January 1, 2023*. Hospitals and ASCs should no longer receive denials due to an outpatient place of service.

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0FJB4ZZ	Inspection of Hepatobiliary Duct, Percutaneous Endoscopic Approach
0FT44ZZ	Resection of Gallbladder, Percutaneous Endoscopic Approach
BF10YZZ	Fluoroscopy of Bile Ducts using Other Contrast
BF50200	Other Imaging of Bile Ducts using Fluorescing Agent, Indocyanine Green Dye, Intraoperative
BF502Z0	Other Imaging of Bile Ducts using Fluorescing Agent, Intraoperative
BF52200	Other Imaging of Gallbladder using Fluorescing Agent, Indocyanine Green Dye, Intraoperative
BF522Z0	Other Imaging of Gallbladder using Fluorescing Agent, Intraoperative
BF53200	Other Imaging of Gallbladder and Bile Ducts using Fluorescing Agent, Indocyanine Green Dye, Intraoperative
BF532Z0	Other Imaging of Gallbladder and Bile Ducts using Fluorescing Agent, Intraoperative

Medicare Hospital Inpatient Payment

MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

MS-DRG	Description	Inpatient Hospital Medicare National Average Payment[4]
411	Cholecystectomy with C.D.E. with MCC[6]	$21,288
412	Cholecystectomy with C.D.E. with CC[6]	$14,466
413	Cholecystectomy with C.D.E. without CC/MCC	$10,570
417	Laparoscopic Cholecystectomy without C.D.E. with MCC[6]	$16,228
418	Laparoscopic Cholecystectomy without C.D.E. with CC[6]	$11,446
419	Laparoscopic Cholecystectomy without C.D.E. without CC/MCC	$9,195

Note: Laparoscopic cholecystectomy procedures, when performed with common bile duct exploration (CBDE) typically map to MS-DRGs 411-413. Laparoscopic cholecystectomy procedures without common bile duct exploration (CBDE) typically map to MS-DRGs 417-419. Medical documentation and proper ICD-10-PCS code selection is important to ensure appropriate MS-DRG assignment.

Percutaneous Endoscopy Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician[‡, 2]		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Percutaneous Biliary Access									
5341[†]	47490	Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation	4.76	9.79	NA	$326	NA	$3,296	$0
5341[†]	47531	Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access	1.30	2.06	12.48	$69	$415	$3,296	$0
5341[†]	47532	Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (e.g., percutaneous transhepatic cholangiogram)	4.25	6.14	24.76	$204	$824	$3,296	$0
5341[†]	47533	Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external	5.38	7.64	34.25	$254	$1,140	$3,296	$1,622
5341[†]	47534	Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; internal-external	7.60	10.69	37.62	$356	$1,252	$3,296	$1,622
5341[†]	47535	Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g., fluoroscopy), and all associated radiological supervision and interpretation	3.95	5.68	26.08	$189	$868	$3,296	$1,622
5341[†]	47536	Exchange of biliary drainage catheter (e.g., external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g., fluoroscopy), and all associated radiological supervision and interpretation	2.61	3.83	18.68	$127	$622	$3,296	$1,622
5301	47537	Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (e.g., with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (e.g., fluoroscopy), and all associated radiological supervision and interpretation	1.84	2.81	14.46	$94	$481	$864	$470
Percutaneous Biliary Stent(s) and Drain Placement									
5361[†,±]	47538	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (e.g., fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access	4.75	6.80	109.95	$226	$3,660	$5,498	$3,826
5361[†]	47539	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (e.g., fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter	8.75	12.35	123.64	$411	$4,115	$5,498	$2,705
5361[†,±]	47540	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (e.g., fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (e.g., external, or internal-external)	9.03	12.72	123.37	$423	$4,107	$5,498	$3,808
5342[†,±]	47541	Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (e.g., rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access	6.75	9.74	34.28	$324	$1,141	$7,208	$4,990
NA	+47542	Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (e.g., fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)	2.85	3.93	14.65	$131	$488	$0	$0
NA	+47543	Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (e.g., brush, forceps, and/or needle), including imaging guidance (e.g., fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)	3.00	4.15	11.55	$138	$384	$0	$0

Percutaneous Endoscopy Procedural Reimbursement Guide (continued)

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician[‡, 2]		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Percutaneous Biliary Stent(s) and Drain Placement (Cont.)									
NA	+47544	Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (e.g., mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (e.g., fluoroscopy), and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	3.28	4.53	24.56	$151	$818	$0	$0
Endoscopy (Diagnostic and Surgical)									
NA	+47550	Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)	3.02	4.85	NA	$161	NA	$0	NA
5342†	47552	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with collection of specimen(s) by brushing and/or washing, when performed (separate procedure)	6.03	8.14	NA	$271	NA	$7,208	$3,722
5342†	47553	Biliary endoscopy, percutaneous via T-tube or other tract; with biopsy, single or multiple	6.34	8.15	NA	$271	NA	$7,208	$3,722
5362†	47554	Biliary endoscopy, percutaneous via T-tube or other tract; with removal of calculus/calculi	9.05	13.14	NA	$437	NA	$9,808	$4,541
5341†,±	47555	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) without stent	7.55	9.71	NA	$323	NA	$3,296	$2,170
5362†±	47556	Biliary endoscopy, percutaneous via T-tube or other tract; with dilation of biliary duct stricture(s) with stent	8.55	11.00	NA	$366	NA	$9,808	$6,092

+CPT Code 47550 is an Add-on code and must be reported with a primary procedure. CMS categorizes this code as a "Type II Add-on Code". Type II Add-on codes do not have a defined set of primary procedure codes. CMS indicates primary procedures are "Contractor Defined" and may therefore vary among Medicare Administrative Carriers (MACs) and private payers.

NOTE: CPT Add-on Code +47550 (Choledochoscopy) has been removed from the "*Inpatient Procedures Only List*", *effective January 1, 2023*. Hospitals and ASCs will no longer receive denials due to an outpatient place of service.

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10-PCS Description
0F2BX0Z	Change Drainage Device in Hepatobiliary Duct, External Approach
0F753DZ	Dilation of Right Hepatic Duct with Intraluminal Device, Percutaneous Approach
0F753ZZ	Dilation of Right Hepatic Duct, Percutaneous Approach
0F754DZ	Dilation of Right Hepatic Duct with Intraluminal Device, Percutaneous Endoscopic Approach
0F754ZZ	Dilation of Right Hepatic Duct, Percutaneous Endoscopic Approach
0F763DZ	Dilation of Left Hepatic Duct with Intraluminal Device, Percutaneous Approach
0F763ZZ	Dilation of Left Hepatic Duct, Percutaneous Approach
0F764DZ	Dilation of Left Hepatic Duct with Intraluminal Device, Percutaneous Endoscopic Approach
0F764ZZ	Dilation of Left Hepatic Duct, Percutaneous Endoscopic Approach
0F773DZ	Dilation of Common Hepatic Duct with Intraluminal Device, Percutaneous Approach
0F773ZZ	Dilation of Common Hepatic Duct, Percutaneous Approach
0F774DZ	Dilation of Common Hepatic Duct with Intraluminal Device, Percutaneous Endoscopic Approach
0F774ZZ	Dilation of Common Hepatic Duct, Percutaneous Endoscopic Approach
0F778DZ	Dilation of Common Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F778ZZ	Dilation of Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F783DZ	Dilation of Cystic Duct with Intraluminal Device, Percutaneous Approach
0F783ZZ	Dilation of Cystic Duct, Percutaneous Approach
0F784DZ	Dilation of Cystic Duct with Intraluminal Device, Percutaneous Endoscopic Approach
0F784ZZ	Dilation of Cystic Duct, Percutaneous Endoscopic Approach
0F793DZ	Dilation of Common Bile Duct with Intraluminal Device, Percutaneous Approach
0F793ZZ	Dilation of Common Bile Duct, Percutaneous Approach
0F794DZ	Dilation of Common Bile Duct with Intraluminal Device, Percutaneous Endoscopic Approach
0F794ZZ	Dilation of Common Bile Duct, Percutaneous Endoscopic Approach
0F7C3ZZ	Dilation of Ampulla of Vater, Percutaneous Approach
0F9430Z	Drainage of Gallbladder with Drainage Device, Percutaneous Approach
0F9530Z	Drainage of Right Hepatic Duct with Drainage Device, Percutaneous Approach
0F9630Z	Drainage of Left Hepatic Duct with Drainage Device, Percutaneous Approach
0F9730Z	Drainage of Common Hepatic Duct with Drainage Device, Percutaneous Approach
0F9830Z	Drainage of Cystic Duct with Drainage Device, Percutaneous Approach

Percutaneous Endoscopy Procedural Reimbursement Guide (continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10-PCS Description
0F9930Z	Drainage of Common Bile Duct with Drainage Device, Percutaneous Approach
0FB44ZX	Excision of Gallbladder, Percutaneous Endoscopic Approach, Diagnostic
0FB53ZX	Excision of Right Hepatic Duct, Percutaneous Approach, Diagnostic
0FB54ZX	Excision of Right Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FB64ZX	Excision of Left Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FB63ZX	Excision of Left Hepatic Duct, Percutaneous Approach, Diagnostic
0FB73ZX	Excision of Common Hepatic Duct, Percutaneous Approach, Diagnostic
0FB74ZX	Excision of Common Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FB83ZX	Excision of Cystic Duct, Percutaneous Approach, Diagnostic
0FB84ZX	Excision of Cystic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FB93ZX	Excision of Common Bile Duct, Percutaneous Approach, Diagnostic
0FC43ZZ	Extirpation of Matter from Gallbladder, Percutaneous Approach
0FC44ZZ	Extirpation of Matter from Gallbladder, Percutaneous Endoscopic Approach
0FC53ZZ	Extirpation of Matter from Right Hepatic Duct, Percutaneous Approach
0FC54ZZ	Extirpation of Matter from Right Hepatic Duct, Percutaneous Endoscopic Approach
0FC63ZZ	Extirpation of Matter from Left Hepatic Duct, Percutaneous Approach
0FC64ZZ	Extirpation of Matter from Left Hepatic Duct, Percutaneous Endoscopic Approach
0FC73ZZ	Extirpation of Matter from Common Hepatic Duct, Percutaneous Approach
0FC74ZZ	Extirpation of Matter from Common Hepatic Duct, Percutaneous Endoscopic Approach
0FC83ZZ	Extirpation of Matter from Cystic Duct, Percutaneous Approach
0FC84ZZ	Extirpation of Matter from Cystic Duct, Percutaneous Endoscopic Approach
0FC93ZZ	Extirpation of Matter from Common Bile Duct, Percutaneous Approach
0FC94ZZ	Extirpation of Matter from Common Bile Duct, Percutaneous Endoscopic Approach
0FD44ZX	Extraction of Gallbladder, Percutaneous Endoscopic Approach, Diagnostic
0FD53ZX	Extraction of Right Hepatic Duct, Percutaneous Approach, Diagnostic
0FD54ZX	Extraction of Right Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FD63ZX	Extraction of Left Hepatic Duct, Percutaneous Approach, Diagnostic
0FD64ZX	Extraction of Left Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FD73ZX	Extraction of Common Hepatic Duct, Percutaneous Approach, Diagnostic
0FD74ZX	Extraction of Common Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FD83ZX	Extraction of Cystic Duct, Percutaneous Approach, Diagnostic
0FD84ZX	Extraction of Cystic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FD93ZX	Extraction of Common Bile Duct, Percutaneous Approach, Diagnostic
0FD94ZX	Extraction of Common Bile Duct, Percutaneous Endoscopic Approach, Diagnostic
0FHB4DZ	Insertion of Intraluminal Device into Hepatobiliary Duct, Percutaneous Endoscopic Approach
0FJ44ZZ	Inspection of Gallbladder, Percutaneous Endoscopic Approach
0FJB4ZZ	Inspection of Hepatobiliary Duct, Percutaneous Endoscopic Approach
0FPBX0Z	Removal of Drainage Device from Hepatobiliary Duct, External Approach
BF000ZZ	Plain Radiography of Bile Ducts using High Osmolar Contrast
BF001ZZ	Plain Radiography of Bile Ducts using Low Osmolar Contrast
BF00YZZ	Plain Radiography of Bile Ducts using Other Contrast
BF030ZZ	Plain Radiography of Gallbladder and Bile Ducts using High Osmolar Contrast
BF031ZZ	Plain Radiography of Gallbladder and Bile Ducts using Low Osmolar Contrast
BF03YZZ	Plain Radiography of Gallbladder and Bile Ducts using Other Contrast
BF0C0ZZ	Plain Radiography of Hepatobiliary System, All using High Osmolar Contrast
BF0C1ZZ	Plain Radiography of Hepatobiliary System, All using Low Osmolar Contrast
BF0CYZZ	Plain Radiography of Hepatobiliary System, All using Other Contrast
BF100ZZ	Fluoroscopy of Bile Ducts using High Osmolar Contrast
BF101ZZ	Fluoroscopy of Bile Ducts using Low Osmolar Contrast
BF10YZZ	Fluoroscopy of Bile Ducts using Other Contrast
BF110ZZ	Fluoroscopy of Biliary and Pancreatic Ducts using High Osmolar Contrast
BF111ZZ	Fluoroscopy of Biliary and Pancreatic Ducts using Low Osmolar Contrast
BF11YZZ	Fluoroscopy of Biliary and Pancreatic Ducts using Other Contrast
BF130ZZ	Fluoroscopy of Gallbladder and Bile Ducts using High Osmolar Contrast
BF131ZZ	Fluoroscopy of Gallbladder and Bile Ducts using Low Osmolar Contrast
BF13YZZ	Fluoroscopy of Gallbladder and Bile Ducts using Other Contrast

Percutaneous Endoscopy Procedural Reimbursement Guide (continued)

Medicare Hospital Inpatient Payment

MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
356	Other Digestive System O.R. Procedures with MCC[6]	$29,958
357	Other Digestive System O.R. Procedures with CC[6]	$15,381
358	Other Digestive System O.R. Procedures without CC/MCC	$8,970
405	Pancreas, Liver and Shunt Procedures with MCC[6]	$38,545
406	Pancreas, Liver and Shunt Procedures with CC[6]	$20,216
407	Pancreas, Liver and Shunt Procedures without CC/MCC	$15,060
408	Biliary Tract Procedures Except Only Cholecystectomy with or without C.D.E. with MCC[6]	$26,061
409	Biliary Tract Procedures Except Only Cholecystectomy with or without C.D.E. with CC[6]	$13,704
410	Biliary Tract Procedures Except Only Cholecystectomy with or without C.D.E. without CC/MCC	$10,959
411	Cholecystectomy with C.D.E. with MCC[6]	$21,288
412	Cholecystectomy with C.D.E. with CC[6]	$14,466
413	Cholecystectomy with C.D.E. without CC/MCC	$10,570
420	Hepatobiliary Diagnostic Procedures with MCC[6]	$22,411
421	Hepatobiliary Diagnostic Procedures with CC[6]	$11,970
422	Hepatobiliary Diagnostic Procedures without CC/MCC	$9,879

Surgical Notes

Airway

Airway Endoscopy Procedural Reimbursement Guide

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Airway Endoscopy Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
Balloon Dilation									
5154†	31630	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with tracheal/bronchial dilation or closed reduction of fracture	3.81	5.82	NA	$194	NA	$3,568	$1,567
Transbronchial Biopsy (TBBX)									
5154†	31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	3.55	5.15	11.11	$171	$370	$3,568	$1,567
NA	+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	1.43	1.93	$48	$64	$0	$0
Bronchial Thermoplasty									
5155†	31660	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe	4.00	5.55	NA	$185	NA	$6,521	N/A
5155†	31661	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 2 or more lobes	4.25	5.86	NA	$195	NA	$6,521	N/A
Cytology and Brushing									
5153†	31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)	2.53	3.90	7.48	$130	$249	$1,617	$757
5153†	31623	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings	2.63	3.87	8.21	$129	$273	$1,617	$757
5153†	31624	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage	2.63	3.92	7.64	$130	$254	$1,617	$757
Endobronchial Ultrasound (EBUS) Guided Transbronchial Biopsy									
5154†	31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	4.46	6.45	37.10	$215	$1,235	$3,568	$1,567
5154†	31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	4.96	7.15	38.51	$238	$1,282	$3,568	$1,567
NA	+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) (List separately in addition to code for primary procedure[s])	1.40	1.96	3.60	$65	$120	$0	$0
Foreign Body Removal (Stent Removal)									
5153†	31635	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of foreign body	3.42	5.15	8.77	$171	$292	$1,617	$757
Transbronchial Needle Aspiration Biopsy (TBNA)									
5154†	31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	3.75	5.47	13.52	$182	$450	$3,568	$1,567
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)	1.32	1.84	2.40	$61	$80	$0	$0
Stenting									
5155†	31631	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	4.36	6.63	NA	$221	NA	$6,521	$2,301
5155†,±	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	6.34	NA	$211	NA	$6,521	$3,077
NA	+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	2.22	NA	$74	NA	$0	$0
5155†	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	7.20	NA	$240	NA	$6,521	$2,301

Airway Notes

Appendix A: APC Reference Table

APC	APC Description	2024 OPPS APC Payment[3]
5071	Level 1 Excision/ Biopsy/ Incision and Drainage	$ 670
5153†	Level 3 Airway Endoscopy	$ 1,617
5154†	Level 4 Airway Endoscopy	$ 3,568
5155†	Level 5 Airway Endoscopy	$ 6,521
5301	Level 1 Upper GI Procedures	$ 864
5302†	Level 2 Upper GI Procedures	$ 1,813
5303†	Level 3 Upper GI Procedures	$ 3,649
5311	Level 1 Lower GI Procedures	$ 871
5312	Level 2 Lower GI Procedures	$ 1,124
5313†	Level 3 Lower GI Procedures	$ 2,675
5331†	Complex GI Procedures	$ 5,430
5341†	Level 1 Abdominal/Peritoneal/Biliary and Related Procedures	$ 3,296
5342†	Level 2 Abdominal/Peritoneal/Biliary and Related Procedures	$ 7,208
5361†	Level 1 Laparoscopy and Related Services	$ 5,498
5362†	Level 2 Laparoscopy and Related Services	$ 9,808
5371†	Level 1 Urology and Related Services	$ 235

Appendix B: Endoscopy C-Code Summary

To determine whether there are relevant C-Codes for any Boston Scientific products, please visit our C-Code Finder.

C-Codes are tracking codes established by the Centers for Medicare & Medicaid Services (CMS) to assist Medicare in establishing future APC payment rates. C-Codes only apply to Medicare hospital outpatient claims. It is very important that hospitals report C-Codes as well as the associated device costs. This will help inform and potentially increase future outpatient hospital payment rates.

For devices packaged in kits, hospitals may bill for the components of the kits that individually qualify for C-Codes. Facilities should bill for the estimated proportion of the kit that the C-Code eligible device comprises.

CMS issued NEW Guidance on Hospital Reporting of C-Code C1889 - Implantable/Insertable Devices. For procedure codes that require the use of devices that are not described by a specific HCPCS code, hospitals should report HCPCS code C1889 (Implantable/insertable device, not otherwise classified) and charges for all devices that are used to perform the procedures. See box below for additional details on CMS guidance.[13]

Devices Must:

- Have received FDA marketing authorization, have received an FDA investigational device exemption (IDE), and have been classified as a Category B device by FDA in accordance with 405.203 through 405.207 and 405.211 through 405.215, or meets another appropriate FDA exemption from premarket review;
- Be an integral part of the service furnished;
- Be used for one patient only;
- Come in contact with human tissue;
- Be surgically implanted or inserted (either permanently or temporarily); and
- Not be either of the following:
  (a) Equipment, an instrument, apparatus, implement, or item of the type for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (CMS Pub. 15-1); or

  (b) A material or supply furnished to a service (for example, a suture, customized surgical kit, scalpel, or clip, other than a radiological site marker).

C-Code	C-Code Description	Devices Impacted
C1601	Endoscope, single-use (i.e., disposable), pulmonary, imaging/illumination device (insertable)	EXALT™ Model B Single-Use Bronchoscope
C1726	Catheter, balloon dilation, non-vascular	CRE™ Single-Use Fixed Wire Esophageal Balloon Dilators CRE Single-Use Wireguided Balloon Dilators CRE PRO Wireguided Balloon Dilatation Catheters CRE PRO Esophageal/Pyloric/Colonic Balloon Dilatation Catheters CRE Pulmonary Balloon Dilatation Catheter Hurricane™ RX Single-Use Biliary Dilatation Balloon Catheters MaxForce™ Biliary Balloon Dilatation Catheters MaxForce TTS Single-Use Balloon Dilators Rigiflex™ II Single-Use Achalasia Balloon Dilators SpyGlass™ Discover Balloon Dilation Catheter
C1748	Endoscope, single-use (i.e. disposable), upper GI, imaging/illumination device (insertable)	EXALT™ Model D Single-Use Duodenoscope
C1769	Guidewire	Dreamwire™ Guidewire Hydra Jagwire™ Guidewire Jagwire™ Guidewire Pathfinder™ Guidewire SpyGlass™ Discover Jagwire™ Guidewire
C1874	Stent, coated/covered, with delivery system	AXIOS™ Stent and Delivery System Agile Fully and Partially Covered Esophageal Stent Systems Polyflex™ Single-Use Esophageal Stent System Ultraflex™ Single-Use Covered Esophageal NG Stent Systems WallFlex™ Biliary RX Partially and Fully Covered Stent Systems WallFlex Fully and Partially Covered Esophageal Stent Systems WallFlex Biliary Fully Covered Stent System RMV WALLSTENT™ Endoscopic Biliary Endoprosthesis Stents
C1876	Stent, non-coated/non-covered, with delivery system	Epic Biliary Endoscopic Stent System Ultraflex Precision Single-Use Colonic Stent System Ultraflex Single-Use Uncovered Esophageal NG Stent Systems WallFlex Single-Use Colonic and Duodenal Stent Systems WallFlex Biliary RX Uncovered Stent System WALLSTENT RX Biliary Endoprosthesis Stent System WALLSTENT Endoscopic Biliary Endoprosthesis Stents WALLSTENT Single-Use Colonic and Duodenal Endoprosthesis with UniStep™ Plus Delivery System

Appendix B: Endoscopy C-Code Summary (continued)

C-Code	C-Code Description	Devices Impacted	
C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser	Super Sheath CBDE	
C2617	Stent, non-coronary, temporary, without delivery system	Advanix™ Biliary and Pancreatic Stents C-Flex™ Single-Use Pigtail Biliary Stent Percuflex™ Duodenal Bend Biliary Stents	
C2625	Stent, non-coronary, temporary, with delivery system	Advanix™ Preloaded Biliary Stent Systems Advanix Pancreatic Stent Kits Flexima™ Biliary Stent Systems Percuflex™ Biliary Stent with Introducer Kits RX Biliary Stents with RX Delivery System™	
C1889	Implantable/insertable device, not otherwise classified	Acquire™ Endoscopic Ultrasound Fine Needle Biopsy (FNB) Device Acquire Pulmonary Endobronchial Ultrasound Fine Needle Biopsy Device Apollo ESG™ System Apollo ESG™ SS System Apollo Revise™ System Apollo Revise™ SX System Autotome™ RX Cannulating Sphincterotome Biliary EHL Probe Captiflex™ Single Use Snares Captivator™ COLD Single-Use Snare Captivator Single Use Snares Captivator EMR Captivator II Single-Use Snares Cellebrity™ Single-Use Endoscopic Cytology Brush Contour™ ERCP Cannulas CoreDx™ Pulmonary Mini-Forceps for Endobronchial Ultrasound Dreamtome™ RX Cannulating Sphincterotome eXcelon™ Transbronchial Aspiration Needle Expect™ Pulmonary Endobronchial Ultrasound Transbronchial Aspiration Needle/Adaptor Expect Slimline Endoscopic Ultrasound Aspiration Needle Extractor™ Pro Retrieval Balloons Gold Probe™ Single-Use Electrohemostasis Catheters Habib™ EndoHPB Bipolar Radiofrequency Catheter Hydratome™ RX Cannulating Sphincterotome Injection Gold Probe™ Single-Use Electrohemostasis/Injection Catheters Interject™ Clear Single-Use Injection Therapy Needle Catheters Jagtome Revolution RX Cannulating Sphincterotome Jagtome RX Cannulating Sphincterotome Microknife™ XL Triple-Lumen Needle Knife Multibite™ Single-Use Multiple Sample Biopsy Forceps	Orbera ® ORISE ProKnife OverStitch™ Profile™ Single-Use Snares Radial Jaw™ 4 Single-Use Biopsy Forceps Rapid Exchange XL Cannula Rescue™ Alligator Grasping Forceps Rescue Rat Tooth/Alligator Grasping Forceps Rescue Rat Tooth Grasping Forceps RX Cholangiogram Kits RX Cytology Brush Wireguided Cytology Brush RX ERCP Cannulas RX Needle Knife XL Triple-Lumen Needle Knife Seal™ Single-Use Biopsy Valve Sensation™ Single-Use Short Throw Snares Single-Use Rotatable Snares Speedband Superview 7™ Multiple Band Ligators SpyBite™ Max Biopsy Forceps SpyGlass™ DS Direct Visualization System SpyGlass™ Discover Digital Catheter SpyGlass™ Discover Imager™ II IOC Catheter SpyGlass™ Discover Retrieval Basket SpyGlass™ DS Direct Visualization System SpyGlass Retrieval Basket SpyGlass Retrieval Snare SpyScope™ DS Access & Delivery Catheter SpyScope DS II Access & Delivery Catheter Stonetome™ Stone Removal Device Tandem™ XL Triple-Lumen ERCP Cannula Trapezoid™ RX Wireguided Retrieval Baskets TRUEtome™ Cannulating Sphincterotomes TRUEtome Dreamwire™ Cannulating Sphincterotome Ultratome™ Double-Lumen Sphincterotome Ultratome XL Triple-Lumen Sphincterotome X-Tack™ Zero Tip™ Airway Retrieval Basket

Footnotes

† Comprehensive APCs (C-APCs): CMS implemented their C-APC policy with the goal of identifying certain high-cost device-related outpatient procedures (formerly "device intensive" APCs). CMS identifies these high-cost, device-related services as the primary service on a claim. All other services reported on the same date will be considered "adjunctive, supportive, related or dependent services" provided to support the delivery of the primary service and will be unconditionally packaged into the OPPS C-APC payment of the primary service. Certain exceptions are defined under CMS's C-APC "complexity adjustment" policy and can be found in the OPPS Addenda files (Addendum J).

± Device Intensive ASC Payment Indicator (Addendum AA)

‡ The 2024 National Average Medicare physician payment rates have been calculated using a 2024 conversion factor of $33.2875. Rate subject to change.

NA "NA" indicates that there is no in-office differential for these codes.

N/A Procedure is not included in Medicare's ASC Covered Procedures List and is not reimbursed when performed in an ASC setting.

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

WallFlex™, Percuflex™ C-Flex™ and Flexima™ Biliary RX Stent Systems as well as WALLSTENT™ Biliary Endoprostheses are not FDA-cleared for use in the pancreatic ducts.

INDICATIONS FOR USE: The WallFlex Biliary RX Fully Covered Stent System RMV is indicated for use in the palliative treatment of biliary strictures produced by malignant neoplasms, relief of malignant biliary obstruction prior to surgery and for indwell up to 12 months in the treatment of benign biliary strictures secondary to chronic pancreatitis.

US: The AXIOS Stent and Electrocautery-Enhanced Delivery System is indicated for use to facilitate transgastric or transduodenal endoscopic drainage of symptomatic pancreatic pseudocysts 6cm in size, and and walled-off necrosis ≥ 6 cm in size with ≥ 70% fluid content that are adherent to the gastric or bowel wall. Once place, the AXIOS Stent functions as an access port allowing passage of standard and therapeutic endoscopes to facilitate debridement, irrigation and cystoscopy. The stent is intended for implantation up to 60 days and should be removed upon confirmation of pseudocyst or walled-off necrosis resolution.

LIMITATIONS: The sale, distribution, and use of the device are restricted to prescription use in accordance with 21 CFR §801.109.

CONTRAINDICATIONS:
• The WallFlex Biliary RX Fully Covered Stent should not be placed in strictures that cannot be dilated enough to pass the delivery system, in a perforated duct, or in very small intrahepatic ducts.
• The WallFlex Biliary RX Fully Covered Stent System RMV should not be used in patients for whom endoscopic techniques are contraindicated.

WARNINGS:
• The safety and effectiveness of the stent has not been established for indwell periods exceeding 12 months, when used in the treatment of benign strictures secondary to chronic pancreatitis.
• The WallFlex Biliary RX Fully Covered Stent System RMV is for single-use only.
• The safety and effectiveness of the WallFlex Biliary RX Fully Covered Stent System RMV for use in the vascular system has not been established.
• The safety and effectiveness of the WallFlex Biliary RX Fully Covered Stent System RMV has not been established in the treatment of benign biliary anastomotic strictures in liver transplant patients and benign biliary post abdominal surgery strictures.
• Testing of overlapped stents has not been conducted.
• The stent contains nickel, which may cause an allergic reaction in individuals with nickel sensitivity.

PLEASE REFER TO THE LABELING FOR A MORE COMPLETE LIST OF WARNINGS, PRECAUTIONS AND CONTRAINDICATIONS

2. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – March 2024 release RVU24A | CMS
3. Center for Medicare and Medicaid Services. CMS Hospital Outpatient & ASC - January 2024 release Addendum B | CMS
4. National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($7,001.60). Source: August 2023 release
5. May include but is not limited to one of the following hemostasis techniques: injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator.
6. The patient's medical record must support the existence and treatment of the complication or co-morbidity.
7. Based on estimate that non-Medicare payment for outpatient hospital services is 2.2 times Medicare payment. Source: The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services. https://www.cbo.gov/publication/57422
8. https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/payment/opps
9. https://www.aapc.com/practice-management/rvus.aspx
10. https://www.medpac.gov/document-type/payment-basic/page/2/
11. Waddill, K, et al. Private Payers Pay Hospitals 247% of Medicare Reimbursement Rate. Health Payer Intelligence. September 2020
12. Congressional Budget Office. The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services. January 20, 2022. https://www.cbo.gov/publication/57422
13. https://www.cms.gov/files/document/r11305cp.pdf

SEQUESTRATION DISCLAIMER: Rates referenced in these guides do not reflect Sequestration, automatic reductions in federal spending that will result in an across-the-board reduction to ALL Medicare rates.

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Effective: 1JAN2024
Expires: 31DEC2024
ENDO-519905-AH