2024 Coding & Payment Quick Reference

Select Laparoscopic Cholecystectomy with and without Common Bile Duct Exploration (CBDE) Procedures

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 Laparoscopic Cholecystectomy procedures and are referenced throughout this 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 Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Laparoscopic Cholecystectomy									
5361†	47562	Laparoscopy, surgical; cholecystectomy	10.47	19.92	NA	$652	NA	$5,498	$2,705
5361†	47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.47	21.65	NA	$709	NA	$5,498	$2,705
5362†	47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	18.00	33.65	NA	$1,102	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	$159	NA	N/A (Included in C-APC payment)	

+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 identified by AMA CPT. CMS indicates the primary procedures are "Contractor Defined" and therefore may 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

See important notes on the uses and limitations of this information on page 2.

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-DRGs resulting from inpatient laparoscopic cholecystectomy with common bile duct exploration procedures may include (but are not limited to):

MS-DRG	Description	Inpatient Hospital Medicare National Average Payment[4]
411	Cholecystectomy with C.D.E. with MCC[5]	$20,168
412	Cholecystectomy with C.D.E. with CC[5]	$14,322
413	Cholecystectomy with C.D.E. without CC/MCC	$10,570
417	Laparoscopic Cholecystectomy without C.D.E. with MCC[5]	$16,228
418	Laparoscopic Cholecystectomy without C.D.E. with CC[5]	$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.

C-Code Information

For all C-Code information, please reference the C-Code Finder

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.

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† 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).

‡ The 2024 National Average Medicare physician payment rates have been calculated using a 2024 conversion factor of $32.7442. Rates subject to change.

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

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

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2. Centers for Medicare and Medicaid Services. CMS Physician Fee Schedule January 2024 release RVU24A | CMS
3. Center for Medicare and Medicaid Services. CMS Hospital Outpatient and Ambulatory Surgery Center Payment Schedules - 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).
5. The patient's medical record must support the existence and treatment of the complication or comorbidity.

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Effective: 1JAN2024
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MS-DRG Rates Expire: 30SEP2024
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