2024 Coding & Payment Quick Reference

Endobariatric Procedural Reimbursement Guide

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.

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

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

Medicare Hospital Outpatient 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	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.

			RVUs			2024 Medicare National Average Payment 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

Intragastric Balloon

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
Intragastric Balloon Placement									
5302[†,±]	43290	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon	3.11	5.38	78.00	$176	$2,554	$1,813	$832
Intragastric Balloon Removal									
5301[†,±]	43291	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	2.80	4.74	13.76	$155	$451	$864	$470

C-Code Information

C1889	Implantable/insertable device, not otherwise classified

Apollo ESG™ System
Apollo ESG™ SS System
Apollo Revise™ System
Apollo Revise™ SX System
Orbera®

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

Disclaimer

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 medically appropriate needs of that patient and the independent medical judgement 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. Information included herein is current as of January 2024 but is subject to change without notice. Rates for services are effective January 1, 2024.

† 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.

N/A Medicare has not developed a rate for the ASC setting as the procedure is typically performed in the hospital setting.

1. Current Procedural Rate (CPT) 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
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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