2023 Coding & Payment Quick Reference
Select Biliary and Cholangioscopy 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 biliary and cholangioscopy procedures and are referenced throughout this guide.

All rates shown are 2023 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Biliary Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2023 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
Diagnostic									
5303[†]	43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	NA	9.43	NA	$320	$3,261	$1,501
Therapeutic									
5303[†]	43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	NA	9.91	NA	$336	$3,261	$1,501
5303[†]	43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	6.50	NA	10.45	NA	$354	$3,261	$1,501
5303[†]	43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	6.50	NA	10.46	NA	$354	$3,261	$1,501
5303[†]	43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	6.63	NA	10.65	NA	$361	$3,261	$1,501
5331[†]	43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (e.g., mechanical, electrohydraulic, lithotripsy)	7.93	NA	12.66	NA	$429	$5,241	$2,273
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	NA	11.07	NA	$375	$3,261	$1,501
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	NA	12.65	NA	$429	$3,261	$1,501
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	NA	13.53	NA	$458	$5,241	$2,970
5303[†]	43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	6.86	NA	11.00	NA	$373	$3,261	$1,501
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	NA	14.09	NA	$477	$5,241	$2,987

Cholangioscopy Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2023 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
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	NA	3.47	NA	$118	$0	$0

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

See important notes on the uses and limitations of this information on page 4.

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
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

See important notes on the uses and limitations of this information on page 4.

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 biliary or cholangioscopy procedures may include (but are not limited to):

MS-DRG	Description	Inpatient Hospital Medicare National Average Payment[4]
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC[5])	$11,992
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC[5])	$7,548
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,802
438	Disorders of pancreas except malignancy with MCC[5]	$11,369
439	Disorders of pancreas except malignancy with CC[5]	$5,966
440	Disorders of pancreas except malignancy without CC/MCC	$4,160
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC[5]	$12,997
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC[5]	$6,489
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$4,472
444	Disorders of the biliary tract with MCC[5]	$11,419
445	Disorders of the biliary tract with CC[5]	$7,543
446	Disorders of the biliary tract without CC/MCC	$5,568

C-Code Information

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

See important notes on the uses and limitations of this information on page 4.

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 2023 but is subject to change without notice. Rates for services are effective January 1, 2023.

† 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 2023 National Average Medicare physician payment rates have been calculated using a 2023 conversion factor of $33.8872. 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) 2022 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 2023 release CMS-1770-F | CMS.
3. Center for Medicare and Medicaid Services. CMS Hospital Outpatient and Ambulatory Surgery Center Payment Schedules - January 2023 release, CMS-1772-FC | 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 ($6,859.50).
5. The patient's medical record must support the existence and treatment of the complication or comorbidity.

Boston Scientific
Advancing science for life™

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.

Effective: 1JAN2023
Expires: 31DEC2023
MS-DRG Rates Expire: 30SEP2023
ENDO-1507005-AA