



2023 Coding & Payment Quick Reference

Select Hemostasis/Clipping 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 Hemostasis 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.

Medicare Physician, Hospital Outpatient, and ASC Payments

| APC | CPT® Code ¹ | Code Description | Work | RVUs | | 2023 Medicare National Average Payment | | | |
|----------------------------|------------------------|---|------|--------------|----------------|--|-------------|-----------------------|-------|
| | | | | Total Office | Total Facility | Physician ² | | Facility ³ | |
| | | | | | | In-Office | In-Facility | Hospital Outpatient | ASC |
| Control of Bleeding | | | | | | | | | |
| 5302† | 43227 | Esophagoscopy, flexible, transoral; with control of bleeding, any method | 2.89 | 17.93 | 4.84 | \$608 | \$164 | \$1,742 | \$752 |
| 5302† | 43255 | Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method | 3.56 | 18.89 | 5.87 | \$640 | \$199 | \$1,742 | \$752 |
| 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 | NA | 7.03 | NA | \$238 | \$1,742 | \$752 |
| 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)6 | 7.02 | NA | 11.25 | NA | \$381 | \$1,742 | \$752 |
| 5312 | 44391 | Colonoscopy through stoma; with control of bleeding, any method | 4.12 | 19.27 | 6.77 | \$653 | \$229 | \$1,083 | \$564 |
| 5312 | 45334 | Sigmoidoscopy, flexible; with control of bleeding, any method | 2.00 | 14.88 | 3.46 | \$504 | \$117 | \$1,083 | \$564 |
| 5312 | 45382 | Colonoscopy, flexible; with control of bleeding, any method | 4.66 | 20.04 | 7.59 | \$679 | \$257 | \$1,083 | \$564 |
| Ligation | | | | | | | | | |
| 5302† | 43205 | Esophagoscopy, flexible, transoral; with band ligation of esophageal varices | 2.44 | NA | 4.13 | NA | \$140 | \$1,742 | \$752 |
| 5302† | 43244 | Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices | 4.40 | NA | 7.18 | NA | \$243 | \$1,742 | \$752 |
| 5312 | 45350 | Sigmoidoscopy, flexible; with band ligation(s) (e.g., hemorrhoids) | 1.68 | 20.28 | 2.96 | \$687 | \$100 | \$1,083 | \$564 |
| 5312 | 45398 | Colonoscopy, flexible; with band ligation(s) (e.g., hemorrhoids) | 4.20 | 24.95 | 6.93 | \$845 | \$235 | \$1,083 | \$564 |
| 5311 | 46221 | Hemorrhoidectomy, internal, by rubber band ligation(s) | 2.36 | 8.54 | 5.77 | \$289 | \$196 | \$831 | \$198 |
| Injection | | | | | | | | | |
| 5302† | 43192 | Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance | 2.79 | NA | 5.06 | NA | \$171 | \$1,742 | \$752 |
| 5302† | 43201 | Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance | 1.72 | 7.84 | 3.05 | \$266 | \$103 | \$1,742 | \$752 |
| 5302† | 43204 | Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices | 2.33 | NA | 3.97 | NA | \$135 | \$1,742 | \$752 |
| 5301 | 43236 | Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance | 2.39 | 12.08 | 4.04 | \$409 | \$137 | \$826 | \$430 |
| 5302† | 43243 | Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices | 4.27 | NA | 6.96 | NA | \$236 | \$1,742 | \$752 |
| 5312 | 44404 | Colonoscopy through stoma; with directed submucosal injection(s), any substance | 3.02 | 12.69 | 5.06 | \$430 | \$171 | \$1,083 | \$564 |
| 5311 | 45335 | Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance | 1.04 | 8.80 | 1.97 | \$298 | \$67 | \$831 | \$433 |
| 5312 | 45381 | Colonoscopy, flexible; with directed submucosal injection(s), any substance | 3.56 | 13.31 | 5.88 | \$451 | \$199 | \$1,083 | \$564 |

See important notes on the uses and limitations of this information on page 3.

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").

C-Code Information

For all C-Code information, please reference the [C-Code Finder](#).

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 ⁵ | \$12,196 |
| 378 | GI hemorrhage with CC ⁵ | \$6,757 |
| 379 | GI hemorrhage without CC/MCC | \$4,348 |
| 432 | Cirrhosis & alcoholic hepatitis with MCC ⁵ | \$12,952 |
| 433 | Cirrhosis & alcoholic hepatitis with CC ⁵ | \$7,133 |
| 434 | Cirrhosis & alcoholic hepatitis without CC/MCC | \$4,306 |

See important notes on the uses and limitations of this information on page 3.

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.

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† Comprehensive APCs (C-APCs): In 2014, CMS implemented their C-APC 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.

‡ 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.

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.



SEQUESTRATION DISCLAIMER: Rates referenced in these guides do not reflect Sequestration, automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates.

Effective: 1JAN2023
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 MS-DRG Rates Expire: 30SEP2023
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