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GUIDEPOINT
Reimbursement Resources

2018 Coding & Payment Quick Reference

Endoscopic Ultrasound-Guided Transluminal Drainage and Endoscopic Necrosectomy Procedures of Pancreatic Pseudocyst and Walled-Off Necrosis

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.

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 Medicare National Average Payment			
					Physician[‡,2]		Facility[3]	
CPT® Code[1]	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Stent Placement								
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	NA	11.53	NA	$415	$2,743[†]	$1,212
Stent Retrieval								
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	9.98	5.22	$359	$188	$743	$387
Endoscopic Necrosectomy								
48999	Unlisted procedure, pancreas	NA	NA	NA	NA	NA	$573	NA

*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	Description
0F9G8ZZ	Drainage of Pancreas, Via Natural or Artificial Opening Endoscopic
0FBG8ZZ	Excision of Pancreas, Via Natural or Artificial Opening Endoscopic

Medicare Hospital Inpatient Payment

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment
405	Pancreas, liver and shunt procedures with MCC	$31,857
406	Pancreas, liver and shunt procedures with CC	$16,842
407	Pancreas, liver and shunt procedures without CC/MCC	$12,159
438	Disorders of pancreas except malignancy with MCC	$10,003
439	Disorders of pancreas except malignancy with CC	$5,269
440	Disorders of pancreas except malignancy without CC/MCC	$3,847

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 or procedures 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 that patient based on medical appropriate needs of that patient and the independent medical judgment of the HCP.

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.

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

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 that are 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.

† 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 2018 National Average Medicare physician payment rates have been calculated using a 2018 conversion factor of $35.9996. Rates subject to change.

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

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2 Center for Medicare and Medicaid Services. CMS Physician Fee Schedule - November 2017 release, CMS-1676-F file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

3 Source: December 27, 2017 Federal Register CMS-1678-CN.

4 National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($6028.08). Source: August 22, 2017 Federal Register.

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 as of January 1, 2018.

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Boston Scientific Corporation
300 Boston Scientific Way
Marlboro, MA 01752
www.bostonscientific.com

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