

## Endoscopy

### THIS PROCEDURAL REIMBURSEMENT GUIDE FOR SELECT ENDOSCOPY PROCEDURES

*provides coding and reimbursement information for physicians and facilities. The Medicare payment amounts shown are national average payments. Actual reimbursement will vary for each provider and institution based on geographic differences in costs, hospital teaching status, and proportion of low-income patients. Please feel free to contact the Boston Scientific reimbursement department if you have any questions at 800.876.9960 x4145.*

#### DESCRIPTION OF PAYMENT METHODS

##### **Physician Billing and Payment**

Medicare and most other insurers typically reimburse physicians based on fee schedules tied to CPT® codes. CPT codes are published by the American Medical Association and used to report medical services and procedures performed by or under the direction of physicians.

##### **Hospital Outpatient Billing and Payment**

Medicare reimburses hospitals for outpatient stays (typically stays of less than 24 hours) under **Ambulatory Payment Classification groups (APCs)**. Medicare assigns a procedure to an APC based on the billed CPT code. Hospitals may receive separate APC payments for each procedure done during the same outpatient visit. Many APCs are subject to reduced payment when multiple procedures are performed on the same day. In most cases, the most significant procedure is paid at 100% and all other procedures are subject to a 50% payment reduction. Physician payment for procedures performed in the outpatient hospital setting follows the same method described above in Physician Billing and Payment.

##### **Hospital Inpatient Billing and Payment**

Many insurers, including Medicare, define inpatient hospital care as an admission (typically stays of greater than 24 hours). A **MS-DRG (Diagnosis-Related Group)** is a system of classifying patients, based on their diagnoses and the procedures performed during their hospital stay. The Center for Medicare and Medicaid Services, which runs the Medicare program, uses MS-DRGs to determine how much to pay hospitals for treating Medicare patients who receive

inpatient care. Private payers may also pay hospitals using MS-DRG-based systems for providing inpatient services. Each of Medicare's 700+ DRGs is assigned a single, fixed payment rate. That payment rate reflects the average cost of caring for patients with similar clinical characteristics who require similar resources (services, supplies, devices, etc.) for their treatment during their hospital stay. One single MS-DRG payment is intended to cover all hospital costs associated with treating an individual during his or her hospital stay, with the exception of "professional" (e.g., physician) charges associated with performing medical procedures.

##### **Free-Standing Clinic/Ambulatory Surgical Center Billing and Payment**

Many procedures are performed outside of the hospital in free-standing clinics. Payments made to free-standing clinics from private insurers depend on the contract the clinic has with the payer. Medicare payments to free-standing clinics are determined in part, by the licensing status of the clinic. If a free-standing clinic is licensed by Medicare as an **Ambulatory Surgical Center (ASC)** it is eligible to be reimbursed for select procedures provided in this setting. Not all procedures that Medicare covers in the hospital setting are eligible for payment in ASCs. Medicare has a list of all services (as defined by CPT code), generally non-surgical, that it covers in the ASC setting. These services are classified into nine payment groupings to determine reimbursement. Physician payment for procedures performed in the ASC setting follows the same method described above in Physician Billing and Payment.

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CPT® Code <sup>1</sup>	Code Description	Physician <sup>2</sup>		Facility			
		2009 Medicare National Average Physician Payment In-office	2009 Medicare National Average Physician Payment Facility	Outpatient <sup>3</sup>		Inpatient <sup>4</sup>	
				2009 Medicare National Average Hospital Payment	2009 Medicare National Average ASC Facility Payment	Possible ICD-9-CM Procedural Codes <sup>6</sup>	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Payment
<b>BILIARY</b>							
<b>Diagnostic</b>							
43260	ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	NA*	\$336	\$1,449	\$660	51.1: Endoscopic retrograde cholangio-pancreatography (ERCP)	435: Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC5) <b>\$9,553</b>
<b>Therapeutic</b>							
43261	ERCP; with biopsy, single or multiple	NA*	\$354	\$1,449	\$660	51.11: Endoscopic retrograde cholangiography (ERC)	436: Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC <sup>5</sup> ) <b>\$6,619</b>
43262	ERCP; with sphincterotomy/papillotomy	NA*	\$415	\$1,449	\$660	51.14: (endoscopic) biopsy of biliary duct or sphincter of Oddi	437: Malignancy of hepatobiliary system or pancreas without CC/MCC <b>\$5,292</b>
43263	ERCP; with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)	NA*	\$411	\$1,449	\$660		441: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC <b>\$9,239</b>
43264	ERCP; with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts	NA*	\$499	\$1,449	\$660		442: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC <b>\$5,458</b>
43265	ERCP; endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method	NA*	\$560	\$1,449	\$660		443: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC <b>\$3,877</b>
43267	ERCP; endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube	NA*	\$414	\$1,449	\$660		444: Disorders of the biliary tract with MCC <b>\$8,653</b>
43271	ERCP; endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)	NA*	\$415	\$1,449	\$660	445: Disorders of the biliary tract with CC <b>\$5,769</b>	
43272	ERCP; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	NA*	\$414	\$1,449	\$660	446: Disorders of the biliary tract without CC/MCC <b>\$4,015</b>	
<b>Stenting</b>							
43268	ERCP; with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct	NA*	\$421	\$1,698	\$736	Disorders of the biliary tract with CC	446: Disorders of the biliary tract without CC/MCC <b>\$4,015</b>
43269	ERCP; with endoscopic retrograde removal of foreign body and/or change of tube or stent	NA*	\$461	\$1,698	\$736		
<b>Fluoroscopy</b>							
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation.	\$0	NA*	No additional payment***	No additional payment***	Disorders of the biliary tract without CC/MCC	446: Disorders of the biliary tract without CC/MCC <b>\$4,015</b>
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation.	\$0	NA*	No additional payment***	No additional payment***		
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation.	\$0	NA*	No additional payment***	No additional payment***		

\* NA = Medicare has not developed a rate for the In-Office or ASC setting as the procedure is typically performed in the hospital setting. For physicians, if the contractor determines the service can be performed in-office, the procedure will be paid at the MD In-facility rate.

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<sup>2</sup>Source: November 19, 2008 Federal Register. MD payments calculated using the 2009 conversion factor of \$36.066.

<sup>3</sup>Source: November 18, 2008 Federal Register.

<sup>4</sup> National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5552.58). Source: October 3, 2008 Federal Register

<sup>5</sup>The patient's medical record must support the existence and treatment of the complication or comorbidity.

<sup>6</sup>Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2006. Craig D. Puckett, Fifth Edition

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				2009 Medicare National Average Hospital Payment	2009 Medicare National Average ASC Facility Payment	Possible ICD-9-CM Procedural Codes <sup>6</sup>	
<b>SPYGLASS® VISUALIZATION SYSTEM</b>							
<b>Diagnostic</b>							
43260 + 43723	ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) + <b>Cholangioscopy</b>	NA*	\$461	\$2,173	\$990	51.1: Endoscopic retrograde cholangiopancreatography (ERCP)	435: Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC5) <b>\$9,553</b>
<b>Therapeutic</b>							
43261+ 43273	ERCP; with biopsy, single or multiple + <b>Cholangioscopy</b>	NA*	\$479	\$2,173	\$990	51.11: Endoscopic retrograde cholangiography (ERC)	436: Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC <sup>5</sup> ) <b>\$6,619</b>
43262	ERCP; with sphincterotomy/papillotomy + <b>Cholangioscopy</b>	NA*	\$540	\$2,173	\$990	51.14: Other closed (endoscopic) biopsy of biliary duct or sphincter of Oddi	437: Malignancy of hepatobiliary system or pancreas without CC/MCC <b>\$5,292</b>
43263	ERCP; with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct) + <b>Cholangioscopy</b>	NA*	\$536	\$2,173	\$990		441: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC <b>\$9,239</b>
43264	ERCP; with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts + <b>Cholangioscopy</b>	NA*	\$624	\$2,173	\$990	442: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC <b>\$5,458</b>	443: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC <b>\$3,877</b>
43265	ERCP; endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method + <b>Cholangioscopy</b>	NA*	\$685	\$2,173	\$990		444: Disorders of the biliary tract with MCC <b>\$8,653</b>
43267	ERCP; endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube + <b>Cholangioscopy</b>	NA*	\$539	\$2,173	\$990	445: Disorders of the biliary tract with CC <b>\$5,769</b>	446: Disorders of the biliary tract without CC/MCC <b>\$4,015</b>
43271	ERCP; endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s) + <b>Cholangioscopy</b>	NA*	\$540	\$2,173	\$990		
43272	ERCP; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique + <b>Cholangioscopy</b>	NA*	\$539	\$2,173	\$990		
<b>Stenting</b>							
43268	ERCP; with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct + <b>Cholangioscopy</b>	NA*	\$546	\$2,422	\$1,066		
43269	ERCP; with endoscopic retrograde removal of foreign body and/or change of tube or stent + <b>Cholangioscopy</b>	NA*	\$586	\$2,422	\$1,066		
<b>Fluoroscopy</b>							
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation.	\$0	NA*	No additional payment***	No additional payment***		
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation.	\$0	NA*	No additional payment***	No additional payment***		
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation.	\$0	NA*	No additional payment***	No additional payment***		

Per coding guidelines, it is possible for hospitals to bill for more than one ERCP CPT code to accurately represent the procedures performed. For one patient visit, highest paying ERCP code paid at 100%, each additional code paid at 50%<sup>3</sup>

For example, if the physician performs an ERCP with sphincterotomy, then performs cholangioscopy and takes a biopsy during the cholangioscopy, the following codes may be reported:

CPT Code 43262:	ERCP; with sphincterotomy, papillotomy	\$1,449
CPT Code 43273:	Endoscopic cannulation of papilla with direct visualization of common bile duct(s)	\$724
CPT Code 43261:	ERCP; with biopsy, single or multiple	\$724
<b>TOTAL Hospital Outpatient Payment</b>		<b>\$2,897</b>

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				2009 Medicare National Average Hospital Payment	2009 Medicare National Average ASC Facility Payment	Possible ICD-9-CM Procedural Codes <sup>6</sup>	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Payment	
<b>BIOPSY</b>								
43202	Esophagoscopy, rigid or flexible; with biopsy, single or multiple	\$260	\$110	\$572	\$337	Inpatient payment information not shown because the dilation procedure will rarely, if ever, be the primary reason for a hospital admission.		
43239	Upper GI endoscopy; with biopsy, single or multiple	\$323	\$166	\$572	\$392			
43261	ERCP; with biopsy, single or multiple	NA*	\$354	\$1,449	\$660			
43600	Biopsy of stomach; by capsule, tube, peroral (one or more specimens)	NA*	\$103	\$572	\$337			
44361	Small intestine endoscopy; with biopsy, single or multiple	NA*	\$168	\$632	\$411			
44377	Small intestine endoscopy, including ileum; with biopsy, single or multiple	NA*	\$311	\$632	\$411			
44382	Ileoscopy, through stoma; with biopsy, single or multiple	NA*	\$80	\$632	\$356			
44386	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple	\$320	\$120	\$594	\$344			
44389	Colonoscopy, through stoma; with biopsy, single or multiple	\$370	\$178	\$594	\$344			
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	\$158	\$70	\$603	\$347			
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	\$159	\$72	\$371	\$259			
45380	Colonoscopy, flexible; with biopsy, single or multiple	\$443	\$251	\$594	\$399			
<b>DILATION</b>								
<b>Balloon</b>								
43220	Esophagoscopy, rigid or flexible; with balloon dilation (< 30-mm diameter)	NA*	\$122	\$572	\$337	Inpatient payment information not shown because the dilation procedure will rarely, if ever, be the primary reason for a hospital admission.		
43249	Upper GI endoscopy; with balloon dilation of esophagus (< 30-mm diameter)	NA*	\$168	\$572	\$392			
43458	Dilation of esophagus with balloon (30-mm or larger) for achalasia	\$362	\$175	\$572	\$338			
45340	Sigmoidoscopy, flexible; with balloon dilation	\$400	\$110	\$603	\$347			
45386	Colonoscopy, flexible; with balloon dilation	\$616	\$256	\$594	\$399			
<b>Balloon and Rigid</b>								
43226	Esophagoscopy, rigid or flexible; with insertion of guide wire followed by dilation over guide wire	NA*	\$136	\$572	\$337			
43245	Upper GI endoscopy; with dilation of gastric outlet obstruction (e.g., wire guided balloon, balloon, bougie)	NA*	\$181	\$572	\$392			
43248	Upper GI endoscopy; with insertion of guide wire followed by dilation of esophagus over guide wire	NA*	\$183	\$572	\$392			

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CPT® Code<sup>1</sup>

Code Description

		Physician <sup>2</sup>		Facility				
				Outpatient <sup>3</sup>		Inpatient <sup>4</sup>		
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<b>ENTERAL FEEDING</b>								
<b>Gastrostomy Tube</b>								
43761	Reposition of gastric feeding tube, through the duodenum	\$118	\$104	\$572	\$337	Inpatient payment information not shown because the dilation procedure will rarely, if ever, be the primary reason for a hospital admission.		
44500	Introduction of long gastrointestinal tube	NA*	\$25	\$304	\$186			
<b>Percutaneous Tube Placement</b>								
43760	Change of gastrostomy tube, percutaneous without imaging or endoscopic guidance	\$312	\$49	\$304	\$163			
43246	Upper GI with directed placement of percutaneous gastrostomy tube	NA*	\$242	\$572	\$392			
44372	Small intestinal endoscopy with placement of percutaneous jejunostomy tube	NA*	\$246	\$632	\$411			
44373	Small intestinal endoscopy with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube	NA*	\$199	\$632	\$411			
49440	Insertion of gastrostomy tube, percutaneous under fluoroscopic guidance	\$1,049	\$237	\$572	\$349			
49441	Insertion of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance	\$1,136	\$259	\$572	\$349			
49442	Insertion of cecostomy or other colonic tube, percutaneous under fluoroscopic guidance	\$1,018	\$214	\$807	NA*			
49446	Conversion of gastostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance	\$951	\$172	\$572	\$349			
49450	Replacement of gastrostomy tube, percutaneous under fluoroscopic guidance	\$711	\$69	\$304	\$186			
49451	Replacement of duodenostomy or jejunostomy tube, percutaneous under fluoroscopic guidance	\$677	\$96	\$304	\$186			
49452	Replacement of gastro-jejunostomy tube, percutaneous under fluoroscopic guidance	\$853	\$150	\$304	\$186			
49460	Mechanical removal of obstructive material from gastostomy, duodenostomy, or jejunostomy (or other colonic tube), any method under fluoroscopic guidance	\$779	\$49	\$304	\$186			
<b>RFA LIVER</b>								
47370	Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency	NA*	\$1,127	\$7,909	NA*		50.24: Percutaneous ablation of liver lesion or tissue	405: Pancreas, liver and shunt procedures with major complication or comorbidity (MCC <sup>5</sup> )
47382	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	NA*	\$822	\$7,909	NA*			
47380	Ablation, open, of one or more liver tumor(s); radiofrequency	NA*	\$1,316	\$0	NA*			
<b>Radiology</b>								
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	\$0	NA*	\$0	NA*	50.23: Open ablation of liver lesion or tissue	407: Pancreas, liver and shunt procedures	
77013	Computerized axial tomographic guidance for, and monitoring of, parenchymal tissue ablation	\$0	NA*	\$0	NA*			
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	\$0	NA*	\$0	NA*			

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				2009 Medicare National Average Hospital Payment	2009 Medicare National Average ASC Facility Payment			
<b>HEMOSTASIS/CLIPPING</b>								
<b>Control of bleeding</b>								
43227	Esophagoscopy, rigid or flexible; with control of bleeding, any method	NA*	\$202	\$572	\$392	42.33: Endoscopic excision or destruction of lesion or tissue of esophagus	<b>377:</b>	
43255	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method*	NA*	\$274	\$572	\$392	44.43: Endoscopic control of gastric or duodenal bleeding	Hemorrhage with Major Complication or Comorbidity (MCC <sup>5</sup> )	
44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding, any method*	NA*	\$252	\$632	\$411	45.13: Other endoscopy of small intestine	<b>\$8,925</b>	
44378	Small bowel endoscopy; with control of bleeding, any method*	NA*	\$399	\$632	\$411	45.43: Endoscopic destruction of other lesion or tissue of large intestine	<b>378:</b>	
44391	Colonoscopy through stoma; with control of bleeding, any method*	\$479	\$243	\$594	\$344	42.33: Endoscopic excision or destruction of lesion or tissue of esophagus	Hemorrhage with Complication or Comorbidity (CC <sup>5</sup> )	
45334	Sigmoidoscopy, flexible; with control of bleeding, any method*	NA*	\$158	\$603	\$347	43.41: Endoscopic excision or destruction of lesion or tissue of stomach	<b>\$5,576</b>	
45382	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding, any method*	\$583	\$320	\$594	\$399	49.45: Ligation of hemorrhoids	<b>379:</b>	
<b>Ligation</b>								
43205	Esophagoscopy; with band ligation of esophageal varices	NA*	\$216	\$572	\$337	42.23: Other esophagoscopy	Hemorrhage without CC/MCC	
43244	Upper GI endoscopy; with band ligation of esophageal or gastric varices	NA*	\$287	\$572	\$392	42.24: Closed (endoscopic) biopsy of esophagus	<b>\$4,201</b>	
46221	Ligation of hemorrhoid(s)	\$216	\$162	\$387	\$124	42.33: Endoscopic excision or destruction of lesion or tissue of esophagus	<b>432:</b>	
<b>Injection</b>								
43201	Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices	\$272	\$124	\$572	\$337	43.41: Endoscopic excision or destruction of lesion or tissue of stomach	Cirrhosis & alcoholic hepatitis with MCC <sup>5</sup>	
43204	Esophagoscopy w/injection sclerosis of esophageal varices	NA*	\$216	\$572	\$337	45.16: Esophagogastro-duodenoscopy (EGD) with closed biopsy	<b>\$9,323</b>	
43236	Upper GI endoscopy; with submucosal injection(s), any substance	\$347	\$170	\$572	\$392	45.43: Endoscopic destruction of other lesion or tissue of large intestine	<b>433:</b>	
43243	Upper GI endoscopy w/injection sclerosis of esophageal/gastric varices	NA*	\$259	\$572	\$392		Cirrhosis & alcoholic hepatitis with CC <sup>5</sup>	
45335	Sigmoidoscopy; with submucosal injection(s), any substance	\$225	\$87	\$371	\$259		<b>\$5,216</b>	
45381	Colonoscopy; with submucosal injection(s), any substance	\$431	\$237	\$594	\$399		<b>434:</b>	
							Cirrhosis & alcoholic hepatitis without CC/MCC	
							<b>\$3,637</b>	

\* NA = Medicare has not developed a rate for the In-Office or ASC setting as the procedure is typically performed in the hospital setting. For physicians, if the contractor determines the service can be performed in-office, the procedure will be paid at the MD In-facility rate.

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<sup>2</sup>Source: November 19, 2008 Federal Register. MD payments calculated using the 2009 conversion factor of \$36.066.

<sup>3</sup>Source: November 18, 2008 Federal Register.

<sup>4</sup> National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5552.58). Source: October 3, 2008 Federal Register

<sup>5</sup>The patient's medical record must support the existence and treatment of the complication or comorbidity.

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**PROCEDURAL REIMBURSEMENT GUIDE**

Select Endoscopy Procedures

Inpatient Information effective through 9/30/2008. All other information effective through 12/31/2009

CPT® Code <sup>1</sup>	Code Description	Physician <sup>2</sup>		Facility					
		2009 Medicare National Average Physician Payment In- office	2009 Medicare National Average Physician Payment In- Facility	Outpatient <sup>3</sup>		Inpatient <sup>4</sup>			
				2009 Medicare National Average Hospital Payment	2009 Medicare National Average ASC Facility Payment	Possible ICD-9-CM Procedural Codes <sup>6</sup>	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Payment		
<b>POLYPECTOMY</b>									
<b>Hot Biopsy</b>									
43250	Upper gastrointestinal endoscopy; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	NA*	\$181	\$572	\$392	Inpatient payment information not shown because the dilation procedure will rarely, if ever, be the primary reason for a hospital admission.			
44365	Small intestinal endoscopy; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	NA*	\$190	\$632	\$411				
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	\$401	\$210	\$594	\$344				
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	\$161	\$75	\$603	\$347				
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	\$263	\$105	\$603	\$347				
45384	Colonoscopy; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	\$435	\$260	\$594	\$399				
<b>Snare</b>									
43217	Esophagoscopy, rigid or flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	\$349	\$163	\$572	\$337			Inpatient payment information not shown because the dilation procedure will rarely, if ever, be the primary reason for a hospital admission.	
43251	Upper gastrointestinal endoscopy; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	NA*	\$211	\$572	\$392				
44364	Small intestinal endoscopy; with removal of tumor(s), polyp(s) or other lesion(s) by snare technique	NA*	\$214	\$632	\$411				
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	\$470	\$247	\$594	\$344				
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	\$182	\$89	\$603	\$347				
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	\$294	\$136	\$603	\$347				
45385	Colonoscopy; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	\$500	\$298	\$594	\$399				
<b>Hot Biopsy or Snare</b>									
45315	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	\$195	\$100	\$603	\$347	Inpatient payment information not shown because the dilation procedure will rarely, if ever, be the primary reason for a hospital admission.			
<b>Other</b>									
43228	Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	NA*	\$216	\$1,676	\$730				

\* NA = Medicare has not developed a rate for the In-Office or ASC setting as the procedure is typically performed in the hospital setting. For physicians, if the contractor determines the service can be performed in-office, the procedure will be paid at the MD In-facility rate.

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CPT® Code <sup>1</sup>	Code Description	Physician <sup>2</sup>		Facility			
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				2009 Medicare National Average Hospital Payment	2009 Medicare National Average ASC Facility Payment	Possible ICD-9-CM Procedural Codes <sup>6</sup>	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Payment
<b>PULMONARY</b>							
<b>Biopsy</b>							
31625	Bronchoscopy; with biopsy(s)	\$325	\$167	\$674	\$423	32.01 Endoscopic excision or destruction of lesion or tissue of bronchus	180: Respiratory neoplasms with Major Complication or Comorbidity (MCC <sup>5</sup> ) <b>\$9,412</b>  181: Respiratory neoplasms pancreas with Complication or Comorbidity (CC <sup>5</sup> ) <b>\$6,839</b>
31628	Bronchoscopy; with transbronchial lung biopsy, single lobe	\$390	\$186	\$674	\$423		
31632	Bronchoscopy, (rigid or flexible); with transbronchial lung biopsy, each additional lobe (report separately in addition to code for primary procedure)	\$74	\$53	\$674	\$412		
<b>Cytology and Brush</b>							
31622	Bronchoscopy; diagnostic, with or without cell washing	\$296	\$141	\$674	\$368	33.23 Other bronchoscopy	182: Respiratory neoplasms without CC/MCC <b>\$4,851</b>  189: Pulmonary edema & respiratory failure <b>\$7,489</b>
31623	Bronchoscopy; with brushing	\$324	\$142	\$674	\$423		
31624	Bronchoscopy; with bronchial alveolar lavage	\$301	\$143	\$674	\$423		
<b>Stenting</b>							
31631	Bronchoscopy; with tracheal dilation and placement of tracheal stent	NA*	\$225	\$1,662	\$725	33.24 Closed endoscopic biopsy of bronchus; bronchoscopy (fiber-optic) with brush biopsy of "lung" brushing or washing for specimen collection, excision (bite) biopsy	193: Simple pneumonia & pleurisy with MCC <sup>5</sup> <b>\$7,955</b>  194: Simple pneumonia & pleurisy with CC <sup>5</sup> <b>\$5,584</b>  195: Simple pneumonia & pleurisy without CC/MCC <b>\$4,062</b>
31636	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, initial bronchus	NA*	\$220	\$1,662	\$725		
31637	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, each additional major bronchus (report separately in addition to code for primary procedure)	NA*	\$78	\$674	\$368		
31638	Bronchoscopy; with tracheal/bronchial dilation and revision of tracheal or bronchial stent inserted at previous session	NA*	\$245	\$1,662	\$725		
<b>Foreign Body Removal (Stent Removal)</b>							
31635	Bronchoscopy; with removal of foreign body	\$334	\$185	\$674	\$423	33.27 Closed endoscopic biopsy of lung; Fiber-optic bronchoscopy with fluoroscopic guidance with biopsy, transbronchial lung biopsy	196: Interstitial lung disease with MCC <sup>5</sup> <b>\$8,896</b>  197: Interstitial lung disease with CC <sup>5</sup> <b>\$6,103</b>  198: Interstitial lung disease without CC/MCC <b>\$4,552</b>  204: Respiratory signs & symptoms <b>\$3,636</b>
31629	aspiration biopsy, trachea, main stem and/or lobar	\$595	\$198	\$674	\$423		
31633	Bronchoscopy, (rigid or flexible); with transbronchial needle aspiration biopsy, each additional lobe (report separately in addition to code for primary procedure)	\$88	\$66	\$674	\$412		
31645	Bronchoscopy; with therapeutic aspiration of tracheobronchial tree (e.g., drainage of lung abscess)	\$291	\$157	\$674	\$368	31.93 Replacement of laryngeal or tracheal stent	205: Other respiratory system diagnoses with MCC <sup>5</sup> <b>\$6,865</b>  206: Other respiratory system diagnoses without CC/MCC <b>\$4,047</b>
<b>Balloon Dilation</b>							
31630	Bronchoscopy; with tracheal or bronchial dilation or closed reduction of fracture	NA*	\$200	\$1,662	\$725	31.99 Other operations on trachea	
31631	Bronchoscopy; with tracheal dilation and placement of tracheal stent	NA*	\$225	\$1,662	\$725		
31636	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, initial bronchus	NA*	\$220	\$1,662	\$725	98.15 Removal of intraluminal foreign body from trachea and bronchus without incision	
31637	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, each additional major bronchus (report separately in addition to code for primary procedure)	NA*	\$78	\$674	\$368		
31638	Bronchoscopy; with tracheal/bronchial dilation and revision of tracheal or bronchial stent inserted at previous session	NA*	\$245	\$1,662	\$725		

\* NA = Medicare has not developed a rate for the In-Office or ASC setting as the procedure is typically performed in the hospital setting. For physicians, if the contractor determines the service can be performed in-office, the procedure will be paid at the MD In-facility rate.

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CPT® Code	Code Description	Physician <sup>1</sup>		Facility <sup>2</sup>		Possible ICD-9-CM Procedural Codes	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Payment
		Outpatient		Inpatient			
		2009 Medicare National Average Physician Payment In office	2009 Medicare National Average Physician Payment Facility	2009 Medicare National Average Hospital Outpat. Payment	2009 Medicare National Average ASC Facility Payment		
<b>STENTING</b>							
<b>Tracheobronchial Stenting</b>							
31631	Bronchoscopy (rigid or flexible); with tracheal dilation and placement of tracheal stent	NA*	\$225	\$1,662	\$725	31.93: Replacement of laryngeal or tracheal stent	374: Digestive malignancy with Major Complication or Comorbidity (MCC <sup>5</sup> ) <b>\$10,952</b> 375: Digestive malignancy with Complication or Comorbidity (CC <sup>5</sup> ) <b>\$6,965</b> 376: Digestive malignancy without CC/MCC <b>\$4,897</b>
31636	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, initial bronchus	NA*	\$220	\$1,662	\$725	42.81: Insertion of permanent tube into esophagus	
31637	Bronchoscopy; with tracheal/bronchial dilation and placement of bronchial stent, each additional major bronchus (report separately in addition to code for primary procedure)	NA*	\$78	\$674	\$368	51.86: Endoscopic insertion of nasobiliary drainage tube	
<b>Biliary Stenting</b>							
43268	ERCP; with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct	NA*	\$421	\$1,698	\$736	51.87: Endoscopic insertion of stent (tube) into bile duct 51.95: Removal of prosthetic device from bile duct	388: GI obstruction with MCC <sup>5</sup> <b>\$8,555</b> 389: GI obstruction with CC <sup>5</sup> <b>\$5,144</b>
43269	ERCP; with endoscopic retrograde removal of foreign body and/or change of tube or stent	NA*	\$461	\$1,698	\$736	52.93: Endoscopic insertion of stent (tube) into pancreatic duct 52.97: Endoscopic insertion of nasopancreatic drainage tube	390: GI obstruction without CC/MCC <b>\$3,526</b> 393: Other digestive system diagnoses with MCC <sup>5</sup> <b>\$8,556</b>
<b>Esophageal Stenting</b>							
43219	Esophagoscopy; with insertion of plastic tube or stent	NA*	\$165	\$1,698	\$681	96.05: Other intubation of respiratory tract 97.05: Replacement of stent (tube) in biliary or pancreatic duct	394: Other digestive system diagnoses with CC <sup>5</sup> <b>\$5,286</b> 395: Other digestive system diagnoses without CC/MCC <b>\$3,756</b>
<b>Colonic and Duodenal Stenting</b>							
43256	Upper GI endoscopy; with stent placement	NA*	\$246	\$1,698	\$767	97.55: Removal of T-tube, other bile duct tube, or liver tube	435: Malignancy of hepatobiliary system or pancreas with MCC <sup>5</sup> <b>\$9,553</b>
44370	Small bowel endoscopy; with stent placement	NA*	\$278	\$1,698	\$1,172	98.02: Removal of intraluminal foreign body from esophagus without incision	436: Malignancy of hepatobiliary system or pancreas with CC <sup>5</sup> <b>\$6,619</b>
44379	Small bowel endoscopy incl./ileum with stent placement	NA*	\$424	\$1,698	\$1,172	98.03: Removal of intraluminal foreign body from stomach and small intestine without incision	437: Malignancy of hepatobiliary system or pancreas without CC/MCC <b>\$5,292</b>
44383	Ileoscopy with stent placement	NA*	\$171	\$1,698	\$1,172	98.04: Removal of intraluminal foreign body from large intestine without incision	438: Disorders of pancreas except malignancy with MCC <sup>5</sup> <b>\$9,447</b>
44397	Colonoscopy through stoma with stent placement	NA*	\$267	\$1,698	\$681		439: Disorders of pancreas except malignancy with CC <sup>5</sup> <b>\$5,686</b>
45327	Proctosigmoidoscopy; with stent placement	NA*	\$113	\$1,698	\$681		440: Disorders of pancreas except malignancy without CC/MCC <b>\$3,874</b>
45345	Sigmoidoscopy; with stent placement	NA*	\$168	\$1,698	\$681		441: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC <sup>5</sup> <b>\$9,329</b>
45387	Colonoscopy; with stent placement	NA*	\$334	\$1,698	\$681		442: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC <sup>5</sup> <b>\$5,458</b>
<b>Foreign Body Removal (Stent Removal)</b>							
43215	Esophagoscopy, rigid or flexible; with removal of foreign body	NA*	\$148	\$572	\$337		443: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC <b>\$3,877</b>
43247	Upper gastrointestinal endoscopy; with removal of foreign body	NA*	\$194	\$572	\$392		444: Disorders of the biliary tract with MCC <sup>5</sup> <b>\$8,653</b>
43269	ERCP; with endoscopic retrograde removal of foreign body and/or change of tube or stent	NA*	\$461	\$1,698	\$736		445: Disorders of the biliary tract with CC <sup>5</sup> <b>\$5,769</b>
44363	Small intestinal endoscopy not including ileum; with removal of foreign body	NA*	\$199	\$632	\$411		446: Disorders of the biliary tract without CC/MCC <b>\$4,015</b>
45307	Proctosigmoidoscopy, rigid; with removal of foreign body	\$176	\$88	\$1,564	\$640		
45332	Sigmoidoscopy, flexible; with removal of foreign body	\$261	\$105	\$371	\$259		
45379	Colonoscopy; with removal of foreign body	\$468	\$261	\$594	\$399		

\* NA = Medicare has not developed a rate for the In-Office or ASC setting as the procedure is typically performed in the hospital setting. For physicians, if the contractor determines the service can be performed in-office, the procedure will be paid at the MD In-facility rate.

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effective through 12/31/2009

CPT® Code <sup>1</sup>	Code Description	Physician <sup>2</sup>		Facility		Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Payment		
				Outpatient <sup>3</sup>			Inpatient <sup>4</sup>	
		2009 Medicare National Average Physician Payment In- office	2009 Medicare National Average Physician Payment In- Facility	2009 Medicare National Average Hospital Outpatient Payment	2009 Medicare National Average ASC Facility Payment		Possible ICD-9-CM Procedural Codes <sup>6</sup>	
<b>SPYGLASS® VISUALIZATION SYSTEM</b>								
<b>Diagnostic</b>								
43260 + 43723	ERCP; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure) + <b>Cholangioscopy</b>	NA*	\$461	\$2,173	\$990	51.1: Endoscopic retrograde cholangiopancreato-graphy (ERCP)  435: Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC5) <b>\$9,553</b>		
<b>Therapeutic</b>								
43261+43 273	ERCP; with biopsy, single or multiple + <b>Cholangioscopy</b>	NA*	\$479	\$2,173	\$990	51.11:  436: Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC <sup>5</sup> ) <b>\$6,619</b>		
43262	ERCP; with sphincterotomy/papillotomy + <b>Cholangioscopy</b>	NA*	\$540	\$2,173	\$990	51.14: Other closed (endoscopic) biopsy of biliary duct or sphincter of Oddi  437: Malignancy of hepatobiliary system or pancreas without CC/MCC <b>\$5,292</b>		
43263	ERCP; with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct) + <b>Cholangioscopy</b>	NA*	\$536	\$2,173	\$990	441: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC <b>\$9,239</b>		
43264	ERCP; with endoscopic retrograde removal of calculus/calculi from biliary and/or pancreatic ducts <b>+Cholangioscopy<sup>7</sup></b>	NA*	\$624	\$2,173	\$990	442: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC <b>\$5,458</b>		
43265	ERCP; endoscopic retrograde destruction, lithotripsy of calculus/calculi, any method+ <b>Cholangioscopy</b>	NA*	\$685	\$2,173	\$990	443: Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC <b>\$3,877</b>		
43267	ERCP; endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube + <b>Cholangioscopy</b>	NA*	\$539	\$2,173	\$990	444: Disorders of the biliary tract with MCC <b>\$8,653</b>		
43271	ERCP; endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)+ <b>Cholangioscopy<sup>7</sup></b>	NA*	\$540	\$2,173	\$990	445: Disorders of the biliary tract with CC <b>\$5,769</b>		
43272	ERCP; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique+ <b>Cholangioscopy</b>	NA*	\$539	\$2,173	\$990	446: Disorders of the biliary tract without CC/MCC <b>\$4,015</b>		
<b>Stenting</b>								
43268	ERCP; with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct + <b>Cholangioscopy<sup>7</sup></b>	NA*	\$546	\$2,422	\$1,066			
43269	ERCP; with endoscopic retrograde removal of foreign body and/or change of tube or stent + <b>Cholangioscopy</b>	NA*	\$586	\$2,422	\$1,066			
<b>Fluoroscopy</b>								
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation.	\$0	NA*	No additional payment***	No additional payment***			
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation.	\$0	NA*	No additional payment***	No additional payment***			
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation.	\$0	NA*	No additional payment***	No additional payment***			

Per coding guidelines, it is possible for hospitals to bill for more than one ERCP CPT code to accurately represent the procedures performed. For one patient visit, highest paying ERCP code paid at 100%, each additional code paid at 50%.<sup>3</sup>

For example, if the physician performs an ERCP with sphincterotomy, then performs cholangioscopy and takes a biopsy during the cholangioscopy, the following codes may be reported:

CPT Code 43262:	ERCP; with sphincterotomy, papillotomy	\$1,449
CPT Code 43273:	Endoscopic cannulation of papilla with direct visualization of common bile duct(s)	\$724
CPT Code 43261:	ERCP; with biopsy, single or multiple	\$724
<b>TOTAL Hospital Outpatient Payment</b>		<b>\$2,897</b>

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<sup>7</sup>SpyGlass® Direct Visualization System is not FDA-cleared for use in the pancreatic ducts. Boston Scientific does not have a SpyGlass® Direct Visualization System device that is FDA-cleared for use in the pancreatic ducts

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