

HEMOSTASIS/CLIPPING

Reimbursement Information



2009 CODING & PAYMENT QUICK REFERENCE

MEDICARE PHYSICIAN, HOSPITAL OUTPATIENT and ASC PAYMENTS

CPT® Code ¹	Code Description	Physician ²		Facility ³	
		MD Payment In-office	MD Payment In-facility	Hospital Outpatient Payment	ASC Payment
HEMOSTASIS/CLIPPING					
Control of bleeding					
43227	Esophagoscopy, rigid or flexible; with control of bleeding, any method	NA**	\$202	\$572	\$392
43255	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with control of bleeding, any method*	NA**	\$272	\$572	\$392
44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding, any method*	NA**	\$252	\$632	\$411
44378	Small bowel endoscopy; with control of bleeding, any method*	NA**	\$399	\$632	\$411
44391	Colonoscopy through stoma; with control of bleeding, any method*	\$479	\$243	\$594	\$344
45334	Sigmoidoscopy, flexible; with control of bleeding, any method*	NA**	\$158	\$603	\$347
45382	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding, any method*	\$583	\$320	\$594	\$399
Ligation					
43205	Esophagoscopy; with band ligation of esophageal varices	NA**	\$216	\$572	\$337
43244	Upper GI endoscopy; with band ligation of esophageal or gastric varices	NA**	\$287	\$572	\$392
46221	Ligation of hemorrhoid(s)	\$215	\$162	\$387	\$124

*May include but is not limited to one of the following hemostasis techniques: injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator

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

¹Source: Beebe et al. (2008). *CPT®2009 Professional Edition*. Chicago: American Medical Association. CPT® is a registered trademark of American Medical Association. All Rights Reserved.

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

³Source: November 18, 2008 Federal Register.

Important - Please Note: Reimbursement information provided by Boston Scientific Corporation (BSC) is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice. BSC makes no representation or warranty regarding this information or its completeness, accuracy or timeliness, or applicability with a particular patient. BSC specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document. BSC encourages providers to submit accurate and appropriate claims for services. Laws, regulations and payer policies concerning reimbursement are complex and change frequently. Providers are responsible for all decisions relating to coding and reimbursement submissions. Accordingly, BSC strongly recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.

HEMOSTASIS/CLIPPING

Reimbursement Information



2009 CODING & PAYMENT QUICK REFERENCE

MEDICARE PHYSICIAN, HOSPITAL OUTPATIENT and ASC PAYMENTS (cont'd)

CPT® Code ¹	Code Description	Physician ²		Facility ³	
		MD Payment In-office	MD Payment In-facility	Hospital Outpatient Payment	ASC Payment
HEMOSTASIS/CLIPPING					
Injection					
43201	Esophagoscopy, rigid or flexible; with injection sclerosis of esophageal varices	\$272	\$124	\$572	\$337
43204	Esophagoscopy w/injection sclerosis of esophageal varices	NA**	\$216	\$572	\$337
43236	Upper GI endoscopy; with submucosal injection(s), any substance	\$347	\$170	\$572	\$392
43243	Upper GI endoscopy w/injection sclerosis of esophageal/gastric varices	NA**	\$259	\$572	\$392
45335	Sigmoidoscopy; with submucosal injection(s), any substance	\$225	\$87	\$371	\$259
45381	Colonoscopy; with submucosal injection(s), any substance	\$431	\$237	\$594	\$399

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. However, if it is used during a separate event (e.g. the placement of a clip for closure of a perforation 2 days following a polypectomy) it is possible to code separately for the procedure if clipping is the only method of closure that is used. The code for this separate procedure 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")

*May include but is not limited to one of the following hemostasis techniques: injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator

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

¹Source: Beebe et al. (2008). *CPT® 2009 Professional Edition*. Chicago: American Medical Association. CPT® is a registered trademark of American Medical Association. All Rights Reserved.

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

³Source: November 18, 2008 Federal Register.

Important - Please Note: Reimbursement information provided by Boston Scientific Corporation (BSC) is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice. BSC makes no representation or warranty regarding this information or its completeness, accuracy or timeliness, or applicability with a particular patient. BSC specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document. BSC encourages providers to submit accurate and appropriate claims for services. Laws, regulations and payer policies concerning reimbursement are complex and change frequently. Providers are responsible for all decisions relating to coding and reimbursement submissions. Accordingly, BSC strongly recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.

2008 CODING & PAYMENT QUICK REFERENCE

MEDICARE HOSPITAL INPATIENT

- Effective October 1, 2007, the Center for Medicare and Medicaid Services (CMS) replaced the Diagnosis Related Groups (DRG) System with the Medicare Severity DRG (MS-DRG) classification system to recognize severity of illness among patients. The new system, which will be phased in over a two-year period, expands the current list of 538 DRGs to a new list of 745 “severity-adjusted” DRGs.
- MS-DRGs resulting from inpatient hemostasis procedures may include (but are not limited to):

MS-DRG	Description	Hospital Inpatient Payment ⁴
377	Hemorrhage with Major Complication or Comorbidity (MCC ⁵)	\$8,925
378	Hemorrhage with Complication or Comorbidity (CC ⁵)	\$5,576
379	Hemorrhage without CC/MCC	\$4,201
432	Cirrhosis & alcoholic hepatitis with MCC ⁵	\$9,323
433	Cirrhosis & alcoholic hepatitis with CC ⁵	\$5,216
434	Cirrhosis & alcoholic hepatitis without CC/MCC	\$3,637

⁴ National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5552.28). Source: October 3, 2008 Federal Register.

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

CPT is a registered trademark of American Medical Association. CPT Codes © 2008 American Medical Association. All Rights Reserved.

Important - Please Note: Reimbursement information provided by Boston Scientific Corporation (BSC) is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice. BSC makes no representation or warranty regarding this information or its completeness, accuracy or timeliness, or applicability with a particular patient. BSC specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document. BSC encourages providers to submit accurate and appropriate claims for services. Laws, regulations and payer policies concerning reimbursement are complex and change frequently. Providers are responsible for all decisions relating to coding and reimbursement submissions. Accordingly, BSC strongly recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.