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GUIDEPOINT
Reimbursement Resources

2017 Coding & Payment Quick Reference

Select Dilation 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.

Medicare Physician, Hospital Outpatient, and ASC Payments

It is important to remember that surgical endoscopy always includes a diagnostic endoscopy (CPT® Code 43200). Therefore, when a diagnostic endoscopy is performed during the same session as a surgical endoscopy, the diagnostic endoscopy code is not separately reported. (CPT Assistant, October 2001)

		RVUs			2017 Medicare National Average Payment				
					Physician‡,2		Facility3		
CPT® Code[1]	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC	Comments
Balloon									
43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)	3.07	NA	5.36	NA	$192	$2,511†	$1,136	The endoscope remains in place as balloon dilation occurs[4]
43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	3.40	NA	5.65	NA	$203	$1,335†	$609	Typically used for achalasia[5]
43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)	2.00	30.40	3.46	$1,091	$124	$1,335†	$609	The endoscope remains in place as balloon dilation occurs[4]
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	4.07	NA	6.69	NA	$240	$1,335†	$609	Typically used for achalasia[5]
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.67	28.82	4.52	$1,034	$162	$1,335†	$609	Does not require a guidewire for balloon dilation
44381	Ileoscopy, through stoma; with transendoscopic balloon dilation	1.38	26.53	2.49	$952	$89	$1,335†	$609	Does not require a guidewire for balloon dilation
44405	Colonoscopy through stoma; with transendoscopic balloon dilation	3.23	15.30	5.38	$549	$193	$878	$475	Does not require a guidewire for balloon dilation
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	1.25	12.23	2.28	$439	$82	$878	$475	Does not require a guidewire for balloon dilation
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	3.77	16.60	6.23	$596	$224	$878	$475	Does not require a guidewire for balloon dilation

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

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MS-DRG Rates Expire: 30SEP2017
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		RVUs			2017 Medicare National Average Payment Physician‡,2		Facility3		
CPT® Code1	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC	Comments
Balloon or Rigid									
43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire	3.31	NA	5.72	NA	$205	$2,511†	$1,136	Guidewire must be used with balloon dilator
43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	4.63	32.66	7.59	$1,172	$272	$1,335†	$609	Retrograde dilation
43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire	2.24	9.02	3.83	$324	$137	$1,335†	$609	Guidewire must be used with balloon dilator
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)	3.08	15.67	5.16	$562	$185	$1,335†	$609	Utilized to report dilation of gastric outlet, native or post-op (e.g. gastro-jejunal bypass)5
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	2.91	9.95	4.88	$357	$175	$700	$378	Guidewire must be used with balloon dilator
45303	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)	1.40	25.61	2.52	$919	$90	$878	$475	

Medicare Hospital Inpatient Payment

Inpatient payment information not shown because the dilation procedure will rarely, if ever, be the primary reason for a hospital admission.

C-Code Information

For all C-Code information, please reference the C-code Finder: www.bostonscientific.com/reimbursement

† 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 2017 National Average Medicare physician payment rates have been calculated using a 2017 conversion factor of $35.8887. 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 - January 2017 release, RVU17A file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

3 Source: January 3, 2017 Federal Register CMS-1656-CN.

4 General Surgery/Gastroenterology 2008 Coding Companion. Ingenix. p. 245-9

5 Source: ASGE 2014 CPT Coding Updates

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, 2017.

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