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GUIDEPOINT
Reimbursement Resources

2017 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.

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2017 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
Control of Bleeding								
43227	Esophagoscopy, flexible, transoral; with control of bleeding, any method	2.89	17.82	4.85	$640	$174	$1,335[†]	$609
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	3.56	18.86	5.91	$677	$212	$1,335[†]	$609
44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)[6]	4.30	NA	7.06	NA	$253	$1,335[†]	$609
44378	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)[6]	7.02	NA	11.32	NA	$406	$1,335[†]	$609
44391	Colonoscopy through stoma; with control of bleeding, any method	4.12	19.66	6.77	$706	$243	$878	$475
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	2.00	15.62	3.46	$561	$124	$878	$475
45382	Colonoscopy, flexible; with control of bleeding, any method	4.66	20.45	7.62	$734	$273	$878	$475
Ligation								
43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices	2.44	NA	4.15	NA	$149	$1,335[†]	$609
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	4.40	NA	7.22	NA	$259	$1,335[†]	$609
45350	Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	1.68	14.87	2.96	$534	$106	$878	$475
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	4.20	19.09	6.90	$685	$248	$878	$475
46221	Hemorrhoidectomy, internal, by rubber band ligation(s)	2.36	7.66	5.48	$275	$197	$668	$177

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

Effective: 1JAN2017
Expires: 31DEC2017
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
Injection								
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	2.79	NA	4.92	NA	$177	$1,335†	$609
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	1.72	6.28	3.02	$225	$108	$1,335†	$609
43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices	2.33	NA	3.99	NA	$143	$1,335†	$609
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	2.39	9.34	4.07	$335	$146	$700	$378
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices	4.27	NA	6.97	NA	$250	$1,335†	$609
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	3.02	10.23	5.05	$367	$181	$878	$475
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	1.04	6.63	1.95	$238	$70	$668	$361
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	3.56	10.99	5.90	$394	$212	$878	$475

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/fistula, 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").

Medicare Hospital Inpatient Payment Rates Effective October 1, 2016 - September 30, 2017

Medicare Severity Diagnosis Related Groups (MS-DRGs) resulting from inpatient hemostasis procedures may include (but are not limited to):

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment4
377	GI Hemorrhage with Major Complication or Comorbidity (MCC5)	$10,573
378	GI Hemorrhage with Complication or Comorbidity (CC5)	$5,880
379	GI Hemorrhage without CC/MCC	$3,916
432	Cirrhosis & alcoholic hepatitis with MCC5	$10,205
433	Cirrhosis & alcoholic hepatitis with CC5	$5,530
434	Cirrhosis & alcoholic hepatitis without CC/MCC	$3,650

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

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C-Code Information

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

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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 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 National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,963.44). Source: August 22, 2016 Federal Register.

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

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

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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