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GUIDEPOINT
Reimbursement Resources

2017 Coding & Payment Quick Reference

Select Procedures Utilizing Spyglass™ Direct Visualization System

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

The American Medical Association approved a new CPT® Code for cholangioscopy that became effective January 1, 2009. The following add-on code may be used to report cholangioscopy procedures using the SpyGlass Direct Visualization System.

		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
Cholangioscopy								
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure*	2.24	NA	3.52	NA	$126	$0	$0

CPT® Code 43273 is an add-on code and must be reported with at least one of the following ERCP codes:

CPT® Code[1]	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Diagnostic								
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	NA	9.48	NA	$340	$2,511†	$1,136
Therapeutic								
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	NA	9.96	NA	$357	$2,511†	$1,136
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	6.50	NA	10.51	NA	$377	$2,511†	$1,136
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	6.50	NA	10.53	NA	$378	$2,511†	$1,136
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	6.63	NA	10.71	NA	$384	$2,511†	$1,136
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	7.93	NA	12.75	NA	$458	$3,941†	$1,753
43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct	6.90	NA	11.14	NA	$400	$2,511†	$1,136
43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed	7.92	NA	12.74	NA	$457	$2,511†	$1,136

See important notes on the uses and limitations of this information on page 4.

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Effective: 1JAN2017
Expires: 31DEC2017
MS-DRG Rates Expire: 30SEP2017
ENDO-47409-AF FEB2017

		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
Stenting								
43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	8.48	NA	13.62	NA	$489	$3,941[†]	$1,753
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	6.86	NA	11.08	NA	$398	$2,511[†]	$1,136
43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	8.84	NA	14.18	NA	$509	$3,941[†]	$1,753

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Medicare Hospital Inpatient Coding

One of the following ICD-10 PCS Procedure Codes may be used to report the procedure:

ICD-10 PCS Procedure Code	Description
BF110ZZ	Fluoroscopy of Biliary and Pancreatic Ducts using High Osmolar Contrast
BF111ZZ	Fluoroscopy of Biliary and Pancreatic Ducts using Low Osmolar Contrast
BF11YZZ	Fluoroscopy of Biliary and Pancreatic Ducts using Other Contrast
0FJB8ZZ	Inspection of Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0FJD8ZZ	Inspection of Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
BF100ZZ	Fluoroscopy of Bile Ducts using High Osmolar Contrast
BF101ZZ	Fluoroscopy of Bile Ducts using Low Osmolar Contrast
BF10YZZ	Fluoroscopy of Bile Ducts using Other Contrast
BF000ZZ	Plain Radiography of Bile Ducts using High Osmolar Contrast
BF001ZZ	Plain Radiography of Bile Ducts using Low Osmolar Contrast
BF00YZZ	Plain Radiography of Bile Ducts using Other Contrast
0F954ZX	Drainage of Right Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0F957ZX	Drainage of Right Hepatic Duct, Via Natural or Artificial Opening, Diagnostic
0F958ZX	Drainage of Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic, Diagnostic
0F964ZX	Drainage of Left Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0F967ZX	Drainage of Left Hepatic Duct, Via Natural or Artificial Opening, Diagnostic
0F968ZX	Drainage of Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic, Diagnostic
0F984ZX	Drainage of Cystic Duct, Percutaneous Endoscopic Approach, Diagnostic
0F987ZX	Drainage of Cystic Duct, Via Natural or Artificial Opening, Diagnostic
0F988ZX	Drainage of Cystic Duct, Via Natural or Artificial Opening Endoscopic, Diagnostic
0F994ZX	Drainage of Common Bile Duct, Percutaneous Endoscopic Approach, Diagnostic
0F997ZX	Drainage of Common Bile Duct, Via Natural or Artificial Opening, Diagnostic
0F998ZX	Drainage of Common Bile Duct, Via Natural or Artificial Opening Endoscopic, Diagnostic
0F9C4ZX	Drainage of Ampulla of Vater, Percutaneous Endoscopic Approach, Diagnostic
0F9C7ZX	Drainage of Ampulla of Vater, Via Natural or Artificial Opening, Diagnostic
0F9C8ZX	Drainage of Ampulla of Vater, Via Natural or Artificial Opening Endoscopic, Diagnostic
0FB44ZX	Excision of Gallbladder, Percutaneous Endoscopic Approach, Diagnostic
0FB54ZX	Excision of Right Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FB57ZX	Excision of Right Hepatic Duct, Via Natural or Artificial Opening, Diagnostic
0FB58ZX	Excision of Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic, Diagnostic
0FB64ZX	Excision of Left Hepatic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FB67ZX	Excision of Left Hepatic Duct, Via Natural or Artificial Opening, Diagnostic
0FB68ZX	Excision of Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic, Diagnostic
0FB84ZX	Excision of Cystic Duct, Percutaneous Endoscopic Approach, Diagnostic
0FB87ZX	Excision of Cystic Duct, Via Natural or Artificial Opening, Diagnostic
0FB88ZX	Excision of Cystic Duct, Via Natural or Artificial Opening Endoscopic, Diagnostic
0FB94ZX	Excision of Common Bile Duct, Percutaneous Endoscopic Approach, Diagnostic
0FB97ZX	Excision of Common Bile Duct, Via Natural or Artificial Opening, Diagnostic
0FB98ZX	Excision of Common Bile Duct, Via Natural or Artificial Opening Endoscopic, Diagnostic
0FBC4ZX	Excision of Ampulla of Vater, Percutaneous Endoscopic Approach, Diagnostic
0FBC7ZX	Excision of Ampulla of Vater, Via Natural or Artificial Opening, Diagnostic
0FBC8ZX	Excision of Ampulla of Vater, Via Natural or Artificial Opening Endoscopic, Diagnostic

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

Medicare Severity Diagnosis Related Groups (MS-DRGs) used in connection with the cholangioscopy procedure may include (but are not limited to):

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC[5])	$10,374
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC[5])	$6,819
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,549
438	Disorders of pancreas except malignancy with MCC[5]	$9,890
439	Disorders of pancreas except malignancy with CC[5]	$5,190
440	Disorders of pancreas except malignancy without CC/MCC	$3,745
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC[5]	$11,277
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC[5]	$5,440
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$3,962
444	Disorders of the biliary tract with MCC[5]	$9,526
445	Disorders of the biliary tract with CC[5]	$6,156
446	Disorders of the biliary tract without CC/MCC	$4,557

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.

* Add-on codes are always listed in addition to the primary procedure code.

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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 General Surgery/Gastroenterology 2010 Coding Companion. Ingenix. p. 259-263.

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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