GUIDEPOINT
Reimbursement Resources

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2018 Procedural Reimbursement Guide

Gastroenterology

THIS PROCEDURAL REIMBURSEMENT GUIDE, FOR SELECT GASTROENTEROLOGY 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.

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 are 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 highest valued procedure is paid at 100% and all other procedures are subject to a 50% payment reduction.

In 2014, CMS implemented their COMPREHENSIVE APCs (C-APCs) 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. Only select gastroenterology APCs are impacted. Procedures that are impacted are flagged (†) throughout the guide.

HOSPITAL INPATIENT BILLING AND PAYMENT: Medicare reimburses hospital inpatient procedures based on the MEDICARE SEVERITY DIAGNOSIS RELATED GROUP (MS-DRG). The MS-DRG is a system of classifying patients based on their diagnoses and the procedures performed during their hospital stay. MS-DRGs closely calibrate payment to the severity of a patient's illness. 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). Private payers may also use MS-DRG based systems or other payer-specific systems to pay hospitals for providing inpatient services. Effective October 1, 2013, Medicare implemented two-midnight stay guidance. Inpatient admittance is presumed to be appropriate if a physician expects a beneficiary's surgical procedure, diagnostic test or other treatment to require a stay in the hospital lasting at least two midnights, and admits the beneficiary to the hospital based on that expectation. Documentation in the medical record must support a reasonable expectation of the need for the beneficiary to require a medically necessary stay lasting at least two midnights. If the inpatient admission lasts fewer than two midnights due to an unforeseen circumstance this also must be clearly documented in the medical record.

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 approved over 3,900 procedures (as defined by CPT Code), for which it will pay the ASC a facility fee.

THIS GUIDE, FOR SELECT GASTROENTEROLOGY PROCEDURES, PROVIDES CODING AND REIMBURSEMENT INFORMATION FOR PHYSICIANS AND FACILITIES.

THE CODES INCLUDED IN THIS GUIDE ARE INTENDED TO REPRESENT TYPICAL ENDOSCOPY PROCEDURES WHERE THERE IS:

1) At least one device approved or cleared by the U.S. Food and Drug Administration (FDA) for use in the listed procedure; and

2) Specific procedural coding guidance provided by a recognized coding or reimbursement authority such as the American Medical Association (AMA) or The Centers for Medicare and Medicaid Services (CMS). This guide is in no way intended to promote the off label use of medical devices.

THE MEDICARE REIMBURSEMENT AMOUNTS SHOWN ARE CURRENTLY PUBLISHED NATIONAL AVERAGE PAYMENTS.

Actual reimbursement will vary for each provider and institution for a variety of reasons including geographic difference in labor and non-labor costs, hospital teaching status, and/or proportion of low-income patients. On average, private payers pay more than Medicare.[7]

Please feel free to contact the Boston Scientific Endoscopy Reimbursement Help Desk at 508.683.4510 or at ENDOreimbursement@bsci.com if you have any questions.

You can find reimbursement updates on our website: WWW.BOSTONSCIENTIFIC.COM/REIMBURSEMENT

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services that are rendered. It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD) and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage, and reimbursement matters.

Biliary Procedural Reimbursement Guide

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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
Diagnostic								
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	NA	9.49	NA	$342	$2,743†	$1,212
Therapeutic								
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	NA	9.97	NA	$359	$2,743†	$1,212
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	6.50	NA	10.50	NA	$378	$2,743†	$1,212
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	6.50	NA	10.51	NA	$378	$2,743†	$1,212
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	6.63	NA	10.71	NA	$386	$2,743†	$1,212
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	7.93	NA	12.73	NA	$458	$4,294†	$1,849
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	$401	$2,743†	$1,212
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	$459	$2,743†	$1,212
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	13.61	NA	$490	$4,294†	$1,849
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	$399	$2,743†	$1,212
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	14.17	NA	$510	$4,294†	$1,849

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS 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

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Biliary Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
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
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
0F987ZX	Drainage of Cystic Duct, Via Natural or Artificial Opening, Diagnostic
0F988ZX	Drainage of Cystic Duct, Via Natural or Artificial Opening Endoscopic, 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
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
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
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
0FB87ZX	Excision of Cystic Duct, Via Natural or Artificial Opening, Diagnostic
0FB88ZX	Excision of Cystic Duct, Via Natural or Artificial Opening Endoscopic, 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
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

Medicare Hospital Inpatient Payment

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC[5])	$10,068
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC[5])	$6,845
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,481
438	Disorders of pancreas except malignancy with MCC[5]	$10,003
439	Disorders of pancreas except malignancy with CC[5]	$5,269
440	Disorders of pancreas except malignancy without CC/MCC	$3,847
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC[5]	$10,946
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC[5]	$5,663
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$4,092
444	Disorders of the biliary tract with MCC[5]	$9,643
445	Disorders of the biliary tract with CC[5]	$6,378
446	Disorders of the biliary tract without CC/MCC	$4,772

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Biopsy Procedural Reimbursement Guide

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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
Cold Biopsy								
43193	Esophagoscopy, rigid, transoral; with biopsy, single or multiple	2.79	NA	4.87	NA	$175	$1,427[†]	$627
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	1.72	8.75	3.02	$315	$109	$1,427[†]	$627
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	2.39	9.78	4.06	$352	$146	$743	$387
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	NA	9.97	NA	$359	$2,743[†]	$1,212
44361	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple	2.77	NA	4.66	NA	$168	$1,427[†]	$627
44377	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple	5.42	NA	8.81	NA	$317	$1,427[†]	$627
44382	Ileoscopy, through stoma; with biopsy, single or multiple	1.17	7.54	2.15	$271	$77	$743	$387
44386	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple	1.50	8.16	2.61	$294	$94	$710	$370
44389	Colonoscopy through stoma; with biopsy, single or multiple	3.02	10.83	5.06	$390	$182	$936	$488
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	1.15	4.11	2.13	$148	$77	$936	$488
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	1.14	7.36	2.10	$265	$76	$710	$370
45380	Colonoscopy, flexible; with biopsy, single or multiple	3.56	11.55	5.91	$416	$213	$936	$488
Hot Biopsy								
43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.30	10.20	3.91	$367	$141	$1,427[†]	$627
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.97	11.35	5.01	$409	$180	$1,427[†]	$627
44365	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.21	NA	5.33	NA	$192	$1,427[†]	$627
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	3.53	10.05	5.84	$362	$210	$936	$488
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1.30	4.61	2.43	$166	$87	$2,316[†]	$1,139
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	1.55	8.40	2.75	$302	$99	$710	$370
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.07	12.83	6.71	$462	$242	$936	$488

Hospital Inpatient Coding and Medicare Payment

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

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Cholangioscopy Procedural Reimbursement Guide

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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	3.51	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:

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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
Diagnostic								
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	5.85	NA	9.49	NA	$342	$2,743†	$1,212
Therapeutic								
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	NA	9.97	NA	$359	$2,743†	$1,212
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	6.50	NA	10.50	NA	$378	$2,743†	$1,212
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	6.50	NA	10.51	NA	$378	$2,743†	$1,212
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	6.63	NA	10.71	NA	$386	$2,743†	$1,212
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	7.93	NA	12.73	NA	$458	$4,294†	$1,849
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	$401	$2,743†	$1,212
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	$459	$2,743†	$1,212
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	13.61	NA	$490	$4,294†	$1,849
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	$399	$2,743†	$1,212
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	14.17	NA	$510	$4,294†	$1,849

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Cholangioscopy Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS 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
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
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
0F987ZX	Drainage of Cystic Duct, Via Natural or Artificial Opening, Diagnostic
0F988ZX	Drainage of Cystic Duct, Via Natural or Artificial Opening Endoscopic, 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
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
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
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
0FB87ZX	Excision of Cystic Duct, Via Natural or Artificial Opening, Diagnostic
0FB88ZX	Excision of Cystic Duct, Via Natural or Artificial Opening Endoscopic, 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
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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Cholangioscopy Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Payment

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC[5])	$10,068
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC[5])	$6,845
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,481
438	Disorders of pancreas except malignancy with MCC[5]	$10,003
439	Disorders of pancreas except malignancy with CC[5]	$5,269
440	Disorders of pancreas except malignancy without CC/MCC	$3,847
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC[5]	$10,946
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC[5]	$5,663
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$4,092
444	Disorders of the biliary tract with MCC[5]	$9,643
445	Disorders of the biliary tract with CC[5]	$6,378
446	Disorders of the biliary tract without CC/MCC	$4,772

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Dilation Procedural Reimbursement Guide

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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
Balloon								
43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)	3.07	NA	5.33	NA	$192	$2,743[†]	$1,212
43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	3.40	NA	5.64	NA	$203	$1,427[†]	$627
43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)	2.00	30.51	3.45	$1,098	$124	$1,427[†]	$627
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	4.07	NA	6.71	NA	$242	$1,427[†]	$627
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.67	29.03	4.50	$1,045	$162	$1,427[†]	$627
44381	Ileoscopy, through stoma; with transendoscopic balloon dilation	1.38	26.32	2.46	$948	$89	$1,427[†]	$627
44405	Colonoscopy through stoma; with transendoscopic balloon dilation	3.23	15.32	5.39	$552	$194	$936	$488
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	1.25	12.34	2.28	$444	$82	$936	$488
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	3.77	16.69	6.23	$601	$224	$936	$488
Balloon or Rigid								
43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire	3.31	NA	5.67	NA	$204	$2,743[†]	$1,212
43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	4.63	32.71	7.57	$1,178	$273	$1,427[†]	$627
43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire	2.24	9.02	3.80	$325	$137	$1,427[†]	$627
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)	3.08	15.78	5.17	$568	$186	$1,427[†]	$627
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	2.91	9.98	4.88	$359	$176	$743	$387
45303	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)	1.40	25.70	2.50	$925	$90	$936	$488

Hospital Inpatient Coding and Medicare Payment

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

Please refer to page 21 for footnotes
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Endoscopic Ultrasound-Guided Procedural Reimbursement Guide
Select Endoscopy Procedures

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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
Upper Gastrointestinal Procedures								
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	3.59	11.56	5.83	$416	$210	$1,427[†]	$627
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)	4.16	NA	6.84	NA	$246	$1,427[†]	$627
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	4.73	NA	7.73	NA	$278	$1,427[†]	$627
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	2.96	8.65	4.95	$311	$178	$2,743[†]	$1,212
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	4.73	NA	7.73	NA	$278	$1,427[†]	$627
Lower Gastrointestinal Procedures								
44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	4.96	NA	8.11	NA	$292	$936	$488
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	2.98	NA	4.99	NA	$180	$936	$488
45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	5.50	NA	8.95	NA	$322	$936	$488

Hospital Inpatient Coding and Medicare Payment

Inpatient payment information not shown because the endoscopic ultrasound-guided fine needle aspiration procedure will rarely, if ever, be the primary reason for a hospital admission.

Please refer to page 21 for footnotes

Endoscopic Ultrasound-Guided Transluminal Drainage and Endoscopic Necrosectomy Procedures of Pancreatic Pseudocyst and Walled-Off Necrosis Procedural Reimbursement Guide

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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
Stent Placement								
43240	Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)	7.15	NA	11.53	NA	$415	$2,743[†]	$1,212
Stent Retrieval								
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	9.98	5.22	$359	$188	$743	$387
Endoscopic Necrosectomy								
48999	Unlisted procedure, pancreas	NA	NA	NA	NA	NA	$573	NA

*Note: Currently, there is no unique Current Procedural Terminology (CPT) code to describe endoscopic necrosectomy. In the absence of a unique code, providers should bill an unlisted procedure code. Providers should submit a cover letter to the payer with the claim that explains the nature of the procedure, equipment required, estimated practice cost, and a comparison of the physician work (time, intensity, risk) with other comparable services for which the payer has an established value.

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	Description
0F9G8ZZ	Drainage of Pancreas, Via Natural or Artificial Opening Endoscopic
0FBG8ZZ	Excision of Pancreas, Via Natural or Artificial Opening Endoscopic

Medicare Hospital Inpatient Payment

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment
405	Pancreas, liver and shunt procedures with MCC	$31,857
406	Pancreas, liver and shunt procedures with CC	$16,842
407	Pancreas, liver and shunt procedures without CC/MCC	$12,159
438	Disorders of pancreas except malignancy with MCC	$10,003
439	Disorders of pancreas except malignancy with CC	$5,269
440	Disorders of pancreas except malignancy without CC/MCC	$3,847

This coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for procedures for which they are not cleared or approved.

The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for that patient based on medical appropriate needs of that patient and the independent medical judgment of the HCP.

MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

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Enteral Feeding Procedural Reimbursement Guide

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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
Gastrostomy Tube Initial Placement								
43246	Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube	3.56	NA	5.88	NA	$212	$1,427[†]	$627
49440	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.93	27.48	5.98	$989	$215	$1,427[†]	$627
Gastrostomy Tube Replacement/Reposition								
43760	Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance	0.90	14.10	1.36	$508	$49	$230	$120
43761	Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition	2.01	3.37	2.98	$121	$107	$230	$120
49450	Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	1.36	18.94	1.93	$682	$69	$743	$387
Jejunostomy Tube								
44373	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube	3.39	NA	5.65	NA	$203	$1,427[†]	$627
49440	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.93	27.48	5.98	$989	$215	$1,427[†]	$627
49446	Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.06	26.47	4.31	$953	$155	$1,427[†]	$627
49452	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	2.86	25.59	4.03	$921	$145	$743	$387
Other Procedures								
49460	Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation and report	0.96	20.98	1.39	$755	$50	$743	$387

Hospital Inpatient Coding and Medicare Payment

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

Please refer to page 21 for footnotes
See important information about the uses and limitations of this document on pages 2 and 3

Hemostasis Procedural Reimbursement Guide

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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	17.95	4.85	$646	$175	$1,427†	$627
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	3.56	18.98	5.91	$683	$213	$1,427†	$627
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)	4.30	NA	7.06	NA	$254	$1,427†	$627
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)	7.02	NA	11.31	NA	$407	$1,427†	$627
44391	Colonoscopy through stoma; with control of bleeding, any method	4.12	19.79	6.75	$712	$243	$936	$488
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	2.00	15.74	3.45	$567	$124	$936	$488
45382	Colonoscopy, flexible; with control of bleeding, any method	4.66	20.57	7.62	$741	$274	$936	$488
Ligation								
43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices	2.44	NA	4.15	NA	$149	$1,427†	$627
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	4.40	NA	7.21	NA	$260	$1,427†	$627
45350	Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	1.68	15.06	2.96	$542	$107	$936	$488
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	4.20	19.50	6.90	$702	$248	$936	$488
46221	Hemorrhoidectomy, internal, by rubber band ligation(s)	2.36	7.72	5.49	$278	$198	$710	$180
Injection								
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	2.79	NA	4.85	NA	$175	$1,427†	$627
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	1.72	6.27	3.01	$226	$108	$1,427†	$627
43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices	2.33	NA	3.97	NA	$143	$1,427†	$627
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	2.39	9.38	4.07	$338	$147	$743	$387
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices	4.27	NA	6.97	NA	$251	$1,427†	$627
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	3.02	10.37	5.08	$373	$183	$936	$488
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	1.04	6.69	1.94	$241	$70	$710	$370
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	3.56	11.05	5.91	$398	$213	$936	$488

Medicare Hospital Inpatient Payment

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
377	GI Hemorrhage with Major Complication or Comorbidity (MCC[5])	$10,333
378	GI Hemorrhage with Complication or Comorbidity (CC[5])	$5,850
379	GI Hemorrhage without CC/MCC	$3,886
432	Cirrhosis & alcoholic hepatitis with MCC[5]	$10,853
433	Cirrhosis & alcoholic hepatitis with CC[5]	$6,157
434	Cirrhosis & alcoholic hepatitis without CC/MCC	$3,787

Please refer to page 21 for footnotes
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Polypectomy Procedural Reimbursement Guide

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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
Hot Biopsy								
43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.30	10.20	3.91	$367	$141	$1,427†	$627
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.97	11.35	5.01	$409	$180	$1,427†	$627
44365	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	3.21	NA	5.33	NA	$192	$1,427†	$627
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	3.53	10.05	5.84	$362	$210	$936	$488
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1.30	4.61	2.43	$166	$87	$2,316†	$1,139
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	1.55	8.40	2.75	$302	$99	$710	$370
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.07	12.83	6.71	$462	$242	$936	$488
Snare								
43217	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.80	10.82	4.72	$390	$170	$1,427†	$627
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.47	12.58	5.78	$453	$208	$1,427†	$627
44364	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.63	NA	6.02	NA	$217	$1,427†	$627
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.03	11.54	6.64	$415	$239	$936	$488
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	1.40	4.79	2.59	$172	$93	$936	$488
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.05	7.68	3.54	$276	$127	$936	$488
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.57	12.13	7.48	$437	$269	$936	$488
Hot Biopsy or Snare								
45315	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	1.70	5.30	3.07	$191	$111	$936	$488
Other								
43229	Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	3.49	18.47	5.80	$665	$209	$2,743†	$1,212
Foreign Body Removal								
43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)	3.51	NA	5.57	NA	$201	$1,427†	$627
43215	Esophagoscopy, flexible, transoral; with removal of foreign body(s)	2.44	10.26	4.14	$369	$149	$1,427†	$627
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	9.98	5.22	$359	$188	$743	$387
44363	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body(s)	3.39	NA	5.65	NA	$203	$1,427†	$627
45307	Proctosigmoidoscopy, rigid; with removal of foreign body	1.60	4.75	2.80	$171	$101	$2,316†	$1,139
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	1.76	7.19	3.08	$259	$111	$936	$488
45379	Colonoscopy, flexible; with removal of foreign body(s)	4.28	11.63	7.02	$419	$253	$936	$488
Endoscopic Mucosal Resection								
43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	4.20	NA	6.90	NA	$248	$1,427†	$627
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	4.87	NA	7.95	NA	$286	$1,427†	$627
44403	Colonoscopy through stoma; with endoscopic mucosal resection	5.50	NA	8.94	NA	$322	$936	$488
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	3.52	NA	5.85	NA	$211	$936	$488
45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.04	NA	9.79	NA	$352	$936	$488

Hospital Inpatient Coding and Medicare Payment

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

Please refer to page 21 for footnotes
See important information about the uses and limitations of this document on pages 2 and 3

Stenting Procedural Reimbursement Guide
Select Endoscopy Procedures

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2018 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
Biliary 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	13.61	NA	$490	$4,294[†]	$1,849
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	$399	$2,743[†]	$1,212
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	14.17	NA	$510	$4,294[†]	$1,849
Esophageal Stenting								
43212	Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.40	NA	5.56	NA	$200	$4,294[†]	$2,774
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.92	NA	6.41	NA	$231	$4,294[†]	$2,850
Colonic and Duodenal Stenting								
44370	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)	4.69	NA	7.83	NA	$282	$4,294[†]	$1,849
44379	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)	7.36	NA	12.03	NA	$433	$4,294[†]	$1,849
44384	Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	2.85	NA	4.49	NA	$162	$2,743[†]	$1,212
44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)	4.70	NA	7.70	NA	$277	$4,294[†]	$2,799
45327	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)	1.90	NA	3.41	NA	$123	$4,294[†]	$1,849
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	2.72	NA	4.53	NA	$163	$4,294[†]	$2,901
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	5.24	NA	8.53	NA	$307	$4,294[†]	$2,840
Foreign Body Removal (Stent Removal)								
43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)	3.51	NA	5.57	NA	$201	$1,427[†]	$627
43215	Esophagoscopy, flexible, transoral; with removal of foreign body(s)	2.44	10.26	4.14	$369	$149	$1,427[†]	$627
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	9.98	5.22	$359	$188	$743	$387
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	$399	$2,743[†]	$1,212
44363	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body(s)	3.39	NA	5.65	NA	$203	$1,427[†]	$627
45307	Proctosigmoidoscopy, rigid; with removal of foreign body	1.60	4.75	2.80	$171	$101	$2,316[†]	$1,139
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	1.76	7.19	3.08	$259	$111	$936	$488
45379	Colonoscopy, flexible; with removal of foreign body(s)	4.28	11.63	7.02	$419	$253	$936	$488

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Stenting Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0DH50DZ	Insertion of Intraluminal Device into Esophagus, Open Approach
0DH50UZ	Insertion of Feeding Device into Esophagus, Open Approach
0DH53DZ	Insertion of Intraluminal Device into Esophagus, Percutaneous Approach
0DH53UZ	Insertion of Feeding Device into Esophagus, Percutaneous Approach
0DH54DZ	Insertion of Intraluminal Device into Esophagus, Percutaneous Endoscopic Approach
0DH54UZ	Insertion of Feeding Device into Esophagus, Percutaneous Endoscopic Approach
0DH57DZ	Insertion of Intraluminal Device into Esophagus, Via Natural or Artificial Opening
0DH57UZ	Insertion of Feeding Device into Esophagus, Via Natural or Artificial Opening
0DH58DZ	Insertion of Intraluminal Device into Esophagus, Via Natural or Artificial Opening Endoscopic
0DH58UZ	Insertion of Feeding Device into Esophagus, Via Natural or Artificial Opening Endoscopic
0D788DZ	Dilation of Small Intestine with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D798DZ	Dilation of Duodenum with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D7A8DZ	Dilation of Jejunum with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D7B8DZ	Dilation of Ileum with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D7E8DZ	Dilation of Large Intestine with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0DH88DZ	Insertion of Intraluminal Device into Small Intestine, Via Natural or Artificial Opening Endoscopic
0DH98DZ	Insertion of Intraluminal Device into Duodenum, Via Natural or Artificial Opening Endoscopic
0DHA8DZ	Insertion of Intraluminal Device into Jejunum, Via Natural or Artificial Opening Endoscopic
0DHB8DZ	Insertion of Intraluminal Device into Ileum, Via Natural or Artificial Opening Endoscopic
0DHE8DZ	Insertion of Intraluminal Device into Large Intestine, Via Natural or Artificial Opening Endoscopic
0DHP8DZ	Insertion of Intraluminal Device into Rectum, Via Natural or Artificial Opening Endoscopic
0D7K8DZ	Dilation of Ascending Colon with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D7L8DZ	Dilation of Transverse Colon with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D7M8DZ	Dilation of Descending Colon with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D7N8DZ	Dilation of Sigmoid Colon with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F758DZ	Dilation of Right Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F768DZ	Dilation of Left Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F788DZ	Dilation of Cystic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F798DZ	Dilation of Common Bile Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0FHB8DZ	Insertion of Intraluminal Device into Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0F7D4DZ	Dilation of Pancreatic Duct with Intraluminal Device, Percutaneous Endoscopic Approach
0C7S0DZ	Dilation of Larynx with Intraluminal Device, Open Approach
0C7S3DZ	Dilation of Larynx with Intraluminal Device, Percutaneous Approach
0C7S4DZ	Dilation of Larynx with Intraluminal Device, Percutaneous Endoscopic Approach
0C7S7DZ	Dilation of Larynx with Intraluminal Device, Via Natural or Artificial Opening
0C7S8DZ	Dilation of Larynx with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0CPS0DZ	Removal of Intraluminal Device from Larynx, Open Approach
0CPS3DZ	Removal of Intraluminal Device from Larynx, Percutaneous Approach
0CPS7DZ	Removal of Intraluminal Device from Larynx, Via Natural or Artificial Opening
0CPS8DZ	Removal of Intraluminal Device from Larynx, Via Natural or Artificial Opening Endoscopic
0B714DZ	Dilation of Trachea with Intraluminal Device, Percutaneous Endoscopic Approach
0B718DZ	Dilation of Trachea with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0BC17ZZ	Extirpation of Matter from Trachea, Via Natural or Artificial Opening
0BC18ZZ	Extirpation of Matter from Trachea, Via Natural or Artificial Opening Endoscopic

Please refer to page 21 for footnotes
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Stenting Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Payment

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC[6])	$10,068
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC[6])	$6,845
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,481
438	Disorders of pancreas except malignancy with MCC[6]	$10,003
439	Disorders of pancreas except malignancy with CC[6]	$5,269
440	Disorders of pancreas except malignancy without CC/MCC	$3,847
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC[6]	$10,946
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC[6]	$5,663
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$4,092
444	Disorders of the biliary tract with MCC[6]	$9,643
445	Disorders of the biliary tract with CC[6]	$6,378
446	Disorders of the biliary tract without CC/MCC	$4,772

Please refer to page 21 for footnotes
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Medicare Hospital Outpatient Facility Payment

APC	Description	2018 Medicare National Average Payment[3]
5301	Level 1 Upper GI Procedures	$743
5302	Level 2 Upper GI Procedures	$1,427†
5303	Level 3 Upper GI Procedures	$2,743†
5311	Level 1 Lower GI Procedures	$710
5312	Level 2 Lower GI Procedures	$936
5313	Level 3 Lower GI Procedures	$2,316†
5331	Complex GI Procedures	$4,294†

† 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.

* Note: There is a separate facility and physician payment for outpatient hospital services. The values in this table refer to the outpatient hospital facility payment only.

Gastroenterology C-Code Summary

C-Code	C-Code Description	Devices Impacted[1]
C1726	Catheter, balloon dilation, non-vascular	CRE™ Single-Use Fixed Wire Esophageal Balloon Dilators
		CRE Single-Use Wireguided Esophageal/Pyloric/Biliary Balloon Dilators
		CRE Single-Use Wireguided Esophageal/Pyloric/Colonic/Biliary Balloon Dilators
		CRE Single-Use Wireguided Biliary Balloon Dilators
		Hurricane™ RX Single-Use Biliary Dilatation Balloon Catheters
		MaxForce™ Biliary Balloon Dilatation Catheters
		MaxForce TTS™ Single-Use Balloon Dilators
		Rigiflex™ II Single-Use Achalasia Balloon Dilators
C1769	Guide wire	All BSC guide wires used in GI procedures: Dreamwire™ Guidewire, Hydra Jagwire™ Guidewire, Jagwire™ Guidewire, Pathfinder™ Guidewire
C1874	Stent, coated/covered, with delivery system	AXIOS™ Stent and Delivery System
		Polyflex™ Single-Use Esophageal Stent System
		Ultraflex™ Single-Use Covered Esophageal NG Stent System – Distal Release
		Ultraflex Single-Use Covered Esophageal NG Stent System – Proximal Release
		Ultraflex Single-Use Covered Large Esophageal NG Stent System – Distal Release
		Ultraflex Single-Use Covered Large Esophageal NG Stent System – Proximal Release
		WallFlex™ Biliary RX Fully Covered Stent System
		WallFlex Biliary RX Partially Covered Stent System
		WallFlex Fully Covered Esophageal Stent
		WallFlex Partially Covered Esophageal Stent System
		WallFlex Biliary Fully Covered Stent System RMV
		WALLSTENT™ Endoscopic Biliary Endoprosthesis Stents
C1876	Stent, non-coated/non-covered, with delivery system	Epic Biliary Endoscopic Stent System
		Ultraflex Precision Single-Use Colonic Stent System
		Ultraflex Single-Use Uncovered Esophageal NG Stent System – Distal Release
		Ultraflex Single-Use Uncovered Esophageal NG Stent System – Proximal Release
		WallFlex Single-Use Colonic Stent System
		WallFlex Single-Use Duodenal Stent System
		WallFlex Biliary RX Uncovered Stent System
		WALLSTENT RX Biliary Endoprosthesis Stent System
		WALLSTENT Endoscopic Biliary Endoprosthesis Stents
		WALLSTENT Single-Use Colonic and Duodenal Endoprosthesis with UniStep™ Plus Delivery System
C2617	Stent, non-coronary, temporary, without delivery system	Advanix™ Biliary Stent
		Advanix Pancreatic Stent
		C-Flex™ Double Pigtail Biliary Stent
		Percuflex™ Duodenal Bend Biliary Stents
C2625	Stent, non-coronary, temporary, with delivery system	Advanix Preloaded Biliary Stent Systems
		Advanix Pancreatic Stent Kits
		Flexima™ Biliary Stent Systems
		Percuflex Duodenal Bend Biliary Stent with Introducer Kit[1]
		RX Biliary Stents with RX Delivery System™

C-Code Reference Tool

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

1 For devices packaged in kits, hospitals may bill for the components of the kits that individually qualify for C-Codes. Facilities should bill for the estimated proportion of the kit that the C-Code eligible device comprises.

Footnotes

† 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 2018 National Average Medicare physician payment rates have been calculated using a 2018 conversion factor of $35.9996. Rates subject to change.

NA "NA" indicates that there is no in-office differential for these codes.

N/A* Medicare has not developed a rate for the ASC setting as the procedure is typically performed in the hospital setting.

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

WallFlex™, Percuflex™ C-Flex™ and Flexima™ Biliary RX Stent Systems as well as WALLSTENT™ Biliary Endoprostheses are not FDA-cleared for use in the pancreatic ducts.

INDICATIONS FOR USE: The WallFlex Biliary RX Fully Covered Stent System RMV is indicated for use in the palliative treatment of biliary strictures produced by malignant neoplasms, relief of malignant biliary obstruction prior to surgery and for indwell up to 12 months in the treatment of benign biliary strictures secondary to chronic pancreatitis.

LIMITATIONS: The sale, distribution, and use of the device are restricted to prescription use in accordance with 21 CFR §801.109.

CONTRAINDICATIONS:

- The WallFlex Biliary RX Fully Covered Stent should not be placed in strictures that cannot be dilated enough to pass the delivery system, in a perforated duct, or in very small intrahepatic ducts.
- The WallFlex Biliary RX Fully Covered Stent System RMV should not be used in patients for whom endoscopic techniques are contraindicated.

WARNINGS:

- The safety and effectiveness of the stent has not been established for indwell periods exceeding 12 months, when used in the treatment of benign strictures secondary to chronic pancreatitis.
- The WallFlex Biliary RX Fully Covered Stent System RMV is for single-use only.
- The safety and effectiveness of the WallFlex Biliary RX Fully Covered Stent System RMV for use in the vascular system has not been established.
- The safety and effectiveness of the WallFlex Biliary RX Fully Covered Stent System RMV has not been established in the treatment of benign biliary anastomotic strictures in liver transplant patients and benign biliary post abdominal surgery strictures.
- Testing of overlapped stents has not been conducted.• The stent contains nickel, which may cause an allergic reaction in individuals with nickel sensitivity.

PLEASE REFER TO THE LABELING FOR A MORE COMPLETE LIST OF WARNINGS, PRECAUTIONS AND CONTRAINDICATIONS

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2 Center for Medicare and Medicaid Services. CMS Physician Fee Schedule - November 2017 release, CMS-1676-F file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

3 Source: December 27, 2017 Federal Register CMS-1678-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 ($6028.08). Source: September 29, 2017 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.

7 Based on estimate that non-Medicare payment for outpatient hospital services is 1.8 times Medicare payment. Source: High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power by Chapin White, Amelia M. Bond and James D. Reschovsky.

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, 2018.

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