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2019 Coding & Payment Quick Reference

Select Enteral Feeding 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.

The following codes are thought to be relevant to Enteral Feeding procedures and are referenced throughout this guide.

All rates shown are 2019 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2019 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	5.86	NA	$211	$1,483[†]	$643
49440	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.93	26.99	5.96	$973	$215	$1,483[†]	$643
Gastrostomy Tube Replacement/Reposition								
43761	Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition	2.01	3.43	2.98	$124	$107	$231	$119
43762	Replacement of gastrostomy tube, with no revision	0.75	6.31	1.09	$227	$39	$231	$119
43763	Replacement of gastrostomy tube, with evision	1.41	9.37	2.41	$338	$87	$231	$119
49450	Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	1.36	18.80	1.92	$678	$69	$762	$392
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	5.62	NA	$203	$1,483[†]	$643
49441	Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	4.52	30.63	7.00	$1,104	$252	$1,483[†]	$643
49446	Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.06	25.95	4.30	$935	$155	$1,483[†]	$643
49452	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	2.86	25.16	4.01	$907	$145	$762	$392

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

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MS-DRG Rates Expire: 30SEP2019
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		RVUs			2019 Medicare National Average Payment Physician‡,2		Facility3	
CPT® Code1	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
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	20.44	1.39	$737	$50	$762	$392

C-Code Information

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

Medicare Hospital Inpatient Payment

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

Please note: 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 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 the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.

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 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. Boston Scientific does not promote the use of its products outside their FDA-approved label. Information included herein is current as of November 2018 but is subject to change without notice. Rates for services are effective January 1, 2019.

† 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 2019 National Average Medicare physician payment rates have been calculated using a 2019 conversion factor of $36.0391. 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 - November 2018 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: November 2, 2018 Federal Register CMS-1695-F and December 28, 2018 Federal Register CMS-1695-CN2.

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, 2019.

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