

2020 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 2020 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

2020 Medicare National Average Payment

CPT® Code ¹	Code Description	RVUs			Physician ^{2,2} Facility ³			
		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	5.80	NA	\$209	\$1,557 ¹	\$663
49440	Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.93	22.35	5.93	\$962	\$214	\$1,557 ¹	\$663
Gastrostomy Tube Replacement/Reposition								
43761	Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition	2.01	1.22	3.01	\$126	\$109	\$235	\$119
43762	Replacement of gastrostomy tube, with no revision	0.75	5.58	1.10	\$233	\$40	\$235	\$119
43763	Replacement of gastrostomy tube, with revision	1.41	7.98	2.44	\$348	\$88	\$235	\$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	17.28	1.91	\$677	\$69	\$786	\$397
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	5.55	NA	\$200	\$1,557 ¹	\$663
49441	Insertion of duodenostomy of jejunostomy tub, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	4.52	25.11	6.99	\$1,090	\$252	\$1,557 ¹	\$663
49446	Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	3.06	22.28	4.30	\$924	\$155	\$1,557 ¹	\$663
49452	Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report	2.86	21.77	4.02	\$898	\$145	\$786	\$397
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	19.73	1.41	\$751	\$51	\$786	\$397

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

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Effective: 1JAN2020
Expires: 31DEC2020
MS-DRG Rates Expire: 30SEP2020
ENDO-47409-AI

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.

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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 OPSS C-APC payment of the primary service with minor exceptions.

‡ The 2020 National Average Medicare physician payment rates have been calculated using a 2020 conversion factor of \$36.0896. 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 2019 release <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.html>

3 January 2020 Federal Register CMS-1717-CN.

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, 2020.

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