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GI – Endoscopy
2020 Procedural Payment Guide

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- Hospital Inpatient Codes and Payments
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- Physician Payment and RVUs

FOR MORE PROCEDURE PAYMENT GUIDES, **CLICK HERE**

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.

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 Gastroenterology procedures and are referenced throughout this guide.

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

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 2019 but is subject to change without notice. Rates for services are effective January 1, 2020.

Biliary Procedural Reimbursement 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

		RVUs			2020 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	9.31	NA	$336	$2,999†	$1,306
Therapeutic								
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	NA	9.76	NA	$352	$2,999†	$1,306
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	6.50	NA	10.30	NA	$372	$2,999†	$1,306
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	6.50	NA	10.30	NA	$372	$2,999†	$1,306
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	6.63	NA	10.49	NA	$379	$2,999†	$1,306
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	7.93	NA	12.51	NA	$451	$4,781†	$1,961
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	10.92	NA	$394	$2,999†	$1,306
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	12.51	NA	$451	$2,999†	$1,306
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	13.36	NA	$482	$4,781†	$1,961
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	6.86	NA	10.86	NA	$392	$2,999†	$1,306
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	13.90	NA	$502	$4,781†	$1,961

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

Please refer to page 26 for footnotes

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Biliary Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
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
0F558ZZ	Destruction of Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F758DZ	Dilation of Right Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F758ZZ	Dilation of Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F568ZZ	Destruction of Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F768DZ	Dilation of Left Hepatic Duct with Intraluminal Device, Endoscopic
0F768ZZ	Dilation of Left Hepatic Duct, Endoscopic
0F578ZZ	Destruction of Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F958ZZ	Drainage of Right Hepatic Duct, Endoscopic
0F9580Z	Drainage of Right Hepatic Duct with Drainage Device, Endoscopic
0F968ZZ	Drainage of Left Hepatic Duct, Endoscopic
0F9680Z	Drainage of Left Hepatic Duct with Drainage Device, Endoscopic
0FB58ZZ	Excision of Right Hepatic Duct, Endoscopic
0FB68ZZ	Excision of Left Hepatic Duct, Endoscopic
0FF58ZZ	Fragmentation in Right Hepatic Duct, Endoscopic
0FF68ZZ	Fragmentation in Left Hepatic Duct, Endoscopic
0FL58ZZ	Occlusion of Right Hepatic Duct, Endoscopic
0FL58DZ	Occlusion of Right Hepatic Duct with Intraluminal Device Endoscopic
0FL68ZZ	Occlusion of Left Hepatic Duct, Endoscopic
0FL68DZ	Occlusion of Left Hepatic Duct with Intraluminal Device, Endoscopic
0FN58ZZ	Release Right Hepatic Duct, Endoscopic
0FN68ZZ	Release Left Hepatic Duct, Endoscopic
0FQ58ZZ	Repair Right Hepatic Duct, Endoscopic
0FQ68ZZ	Repair Left Hepatic Duct, Endoscopic
0FT58ZZ	Resection of Right Hepatic Duct, Endoscopic
0FT68ZZ	Resection of Left Hepatic Duct, Endoscopic
0FV58ZZ	Restriction of Right Hepatic Duct, Endoscopic
0FV58DZ	Restriction of Right Hepatic Duct with Intraluminal Device, Endoscopic
0FV68ZZ	Restriction of Left Hepatic Duct, Endoscopic
0FV68DZ	Restriction of Left Hepatic Duct with Intraluminal Device, Endoscopic
0F598ZZ	Destruction of Common Bile Duct, 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
0F778DZ	Dilation of Common Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F778ZZ	Dilation of Common Hepatic Duct, 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, Endoscopic

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Biliary Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0F798ZZ	Dilation of Common Bile Duct, Endoscopic
0F998ZZ	Drainage of Common Bile Duct, Endoscopic
0FB98ZZ	Excision of Common Bile Duct, Endoscopic
0FC58ZZ	Extirpation of Matter from Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC68ZZ	Extirpation of Matter from Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC78ZZ	Extirpation of Matter from Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC88ZZ	Extirpation of Matter from Cystic Duct, Via Natural or Artificial Opening Endoscopic
0FC98ZZ	Extirpation of Matter from Common Bile Duct, Endoscopic
0FF98ZZ	Fragmentation in Common Bile Duct, Endoscopic
0FL98ZZ	Occlusion of Common Bile Duct, Endoscopic
0FL98DZ	Occlusion of Common Bile Duct with Intraluminal Device, Endoscopic
0FT98ZZ	Resection of Common Bile Duct, Endoscopic
0FV98ZZ	Restriction of Common Bile Duct, Endoscopic
0FV98DZ	Restriction of Common Bile Duct with Intraluminal Device, Endoscopic
0FN98ZZ	Release Common Bile Duct, Endoscopic
0FQ98ZZ	Repair Common Bile Duct, Endoscopic
0F788DZ	Dilation of Cystic Duct with Intraluminal Device, Endoscopic
0F788ZZ	Dilation of Cystic Duct, Endoscopic
0F5D8ZZ	Destruction of Pancreatic Duct, Endoscopic
0F7D8ZZ	Dilation of Pancreatic Duct, Endoscopic
0F7D8DZ	Dilation of Pancreatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F7F8DZ	Dilation of Accessory Pancreatic Duct with Intraluminal Device, Endoscopic
0F7F8ZZ	Dilation of Accessory Pancreatic Duct, Endoscopic
0F9D8ZX	Drainage of Pancreatic Duct, Endoscopic, Diagnostic
0F9D8ZZ	Drainage of Pancreatic Duct, Endoscopic
0FBD8ZX	Excision of Pancreatic Duct, Endoscopic, Diagnostic
0FBD8ZZ	Excision of Pancreatic Duct, Endoscopic
0FCD8ZZ	Extirpation of Matter from Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FCF8ZZ	Extirpation of Matter from Accessory Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FFD8ZZ	Fragmentation in Pancreatic Duct, Endoscopic
0FLD8ZZ	Occlusion of Pancreatic Duct, Endoscopic
0FNF8ZZ	Release Accessory Pancreatic Duct, Endoscopic
0FQF8ZZ	Repair Accessory Pancreatic Duct, Endoscopic
0FTD8ZZ	Resection of Pancreatic Duct, Endoscopic
0FVD8ZZ	Restriction of Pancreatic Duct, Endoscopic
0FVF8DZ	Restriction of Access Pancreatic Duct with Intraluminal Device, Endoscopic
0FPD80Z	Removal of Drainage Device from Pancreatic Duct, Endoscopic
0FPD81Z	Removal of Radioactive Element from Pancreatic Duct, Endoscopic
0FPD82Z	Removal of Monitoring Device from Pancreatic Duct, Endoscopic
0FPD83Z	Removal of Infusion Device from Pancreatic Duct, Endoscopic
0FPD87Z	Removal of Autologous Tissue Substitute from Pancreatic Duct, Endoscopic
0FPD8CZ	Removal of Extraluminal Device from Pancreatic Duct, Endoscopic
0FPD8DZ	Removal of Intraluminal Device from Pancreatic Duct, Endoscopic
0FPD8JZ	Removal of Synthetic Substitute from Pancreatic Duct, Endoscopic
0FPD8KZ	Removal of Nonautologous Tissue Substitute from Pancreatic Duct, Endoscopic
0FPD8YZ	Removal of Other Device from Pancreatic Duct, Endoscopic
0FWD80Z	Revision of Drainage Device in Pancreatic Duct, Endoscopic
0FWD82Z	Revision of Monitoring Device in Pancreatic Duct, Endoscopic
0FWD83Z	Revision of Infusion Device in Pancreatic Duct, Endoscopic

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Biliary Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0FWD8CZ	Revision of Extraluminal Device in Pancreatic Duct, Endoscopic
0FWD8DZ	Revision of Intraluminal Device in Pancreatic Duct, Endoscopic
0FWD8JZ	Revision of Synthetic Substitute in Pancreatic Duct, Endoscopic
0FHD8DZ	Insertion of Intraluminal Device into Pancreatic Duct, Endoscopic
0FND8ZZ	Release Pancreatic Duct, Endoscopic
0FQD8ZZ	Repair Pancreatic Duct, Endoscopic
0FNC8ZZ	Release Ampulla of Vater, Endoscopic
0FQC8ZZ	Repair Ampulla of Vater, Endoscopic
0F5C8ZZ	Destruction of Ampulla of Vater, Endoscopic
0F7C8DZ	Dilation of Ampulla of Vater with Intraluminal Device, Endoscopic
0F7C8ZZ	Dilation of Ampulla of Vater, Endoscopic
0F9C80Z	Drainage of Ampulla of Vater with Drainage Device, Endoscopic
0F9C8ZZ	Drainage of Ampulla of Vater, Endoscopic
0FBC8ZZ	Excision of Ampulla of Vater, Endoscopic
0FCC8ZZ	Extirpation of Matter from Ampulla of Vater, Via Natural or Artificial Opening Endoscopic
0FFC8ZZ	Fragmentation in Ampulla of Vater, Endoscopic
0FLC8DZ	Occlusion of Ampulla of Vater with Intraluminal Device, Endoscopic
0FLC8ZZ	Occlusion of Ampulla of Vater, Endoscopic
0FTC8ZZ	Resection of Ampulla of Vater, Endoscopic
0FVC8DZ	Restriction of Ampulla of Vater with Intraluminal Device, Endoscopic
0FVC8ZZ	Restriction of Ampulla of Vater, Endoscopic

Medicare Hospital Inpatient Payment

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.

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC[5])	$10,622
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC[5])	$7,046
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,495
438	Disorders of pancreas except malignancy with MCC[5]	$10,254
439	Disorders of pancreas except malignancy with CC[5]	$5,303
440	Disorders of pancreas except malignancy without CC/MCC	$3,853
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC[5]	$11,582
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC[5]	$5,842
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$4,258
444	Disorders of the biliary tract with MCC[5]	$10,178
445	Disorders of the biliary tract with CC[5]	$6,725
446	Disorders of the biliary tract without CC/MCC	$5,087

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Biopsy Procedural Reimbursement 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

		RVUs			2020 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	4.85	NA	$175	$1,557†	$663
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	1.72	7.69	2.97	$348	$107	$1,557†	$663
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	2.39	7.96	3.99	$384	$144	$786	$397
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	NA	9.76	NA	$352	$2,999†	$1,306
44361	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple	2.77	NA	4.57	NA	$165	$1,557†	$663
44377	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple	5.42	NA	8.63	NA	$311	$1,557†	$663
44382	Ileoscopy, through stoma; with biopsy, single or multiple	1.17	6.84	2.10	$294	$76	$786	$397
44386	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); with biopsy, single or multiple	1.50	6.86	2.57	$308	$93	$764	$386
44389	Colonoscopy through stoma; with biopsy, single or multiple	3.02	8.03	4.97	$413	$179	$1,004	$507
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	1.15	3.29	2.10	$167	$76	$1,004	$507
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	1.14	6.56	2.06	$283	$74	$764	$386
45380	Colonoscopy, flexible; with biopsy, single or multiple	3.56	8.16	5.79	$438	$209	$1,004	$507
Hot Biopsy								
43216	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.30	8.62	3.86	$404	$139	$1,557†	$663
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.97	8.94	4.94	$446	$178	$1,557†	$663
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	5.24	NA	$189	$1,557†	$663
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	3.53	6.52	5.78	$382	$209	$1,004	$507
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1.30	3.63	2.44	$189	$88	$2,344†	$1,100
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	1.55	7.15	2.71	$322	$98	$764	$386
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.07	8.90	6.60	$488	$238	$1,004	$507

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

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

		RVUs			2020 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	3.47	NA	$125	$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			2020 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	9.31	NA	$336	$2,999†	$1,306
Therapeutic								
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	6.15	NA	9.76	NA	$352	$2,999†	$1,306
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	6.50	NA	10.30	NA	$372	$2,999†	$1,306
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	6.50	NA	10.30	NA	$372	$2,999†	$1,306
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	6.63	NA	10.49	NA	$379	$2,999†	$1,306
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	7.93	NA	12.51	NA	$451	$4,781†	$1,961
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	10.92	NA	$394	$2,999†	$1,306
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	12.51	NA	$451	$2,999†	$1,306
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	13.36	NA	$482	$4,781†	$1,961
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	6.86	NA	10.86	NA	$392	$2,999†	$1,306
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	13.90	NA	$502	$4,781†	$1,961

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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
0F558ZZ	Destruction of Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F758DZ	Dilation of Right Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F758ZZ	Dilation of Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F568ZZ	Destruction of Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F768DZ	Dilation of Left Hepatic Duct with Intraluminal Device, Endoscopic
0F768ZZ	Dilation of Left Hepatic Duct, Endoscopic
0F578ZZ	Destruction of Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F958ZZ	Drainage of Right Hepatic Duct, Endoscopic
0F9580Z	Drainage of Right Hepatic Duct with Drainage Device, Endoscopic
0F968ZZ	Drainage of Left Hepatic Duct, Endoscopic
0F9680Z	Drainage of Left Hepatic Duct with Drainage Device, Endoscopic
0FB58ZZ	Excision of Right Hepatic Duct, Endoscopic
0FB68ZZ	Excision of Left Hepatic Duct, Endoscopic

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Cholangioscopy Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0FF58ZZ	Fragmentation in Right Hepatic Duct, Endoscopic
0FF68ZZ	Fragmentation in Left Hepatic Duct, Endoscopic
0FL58ZZ	Occlusion of Right Hepatic Duct, Endoscopic
0FL58DZ	Occlusion of Right Hepatic Duct with Intraluminal Device Endoscopic
0FL68ZZ	Occlusion of Left Hepatic Duct, Endoscopic
0FL68DZ	Occlusion of Left Hepatic Duct with Intraluminal Device, Endoscopic
0FN58ZZ	Release Right Hepatic Duct, Endoscopic
0FN68ZZ	Release Left Hepatic Duct, Endoscopic
0FQ58ZZ	Repair Right Hepatic Duct, Endoscopic
0FQ68ZZ	Repair Left Hepatic Duct, Endoscopic
0FT58ZZ	Resection of Right Hepatic Duct, Endoscopic
0FT68ZZ	Resection of Left Hepatic Duct, Endoscopic
0FV58ZZ	Restriction of Right Hepatic Duct, Endoscopic
0FV58DZ	Restriction of Right Hepatic Duct with Intraluminal Device, Endoscopic
0FV68ZZ	Restriction of Left Hepatic Duct, Endoscopic
0FV68DZ	Restriction of Left Hepatic Duct with Intraluminal Device, Endoscopic
0F598ZZ	Destruction of Common Bile Duct, Endoscopic
0F798DZ	Dilation of Common Bile Duct with Intraluminal Device, Endoscopic
0F798ZZ	Dilation of Common Bile Duct, Endoscopic
0F998ZZ	Drainage of Common Bile Duct, Endoscopic
0FB98ZZ	Excision of Common Bile Duct, Endoscopic
0FC98ZZ	Extirpation of Matter from Common Bile Duct, Endoscopic
0FF98ZZ	Fragmentation in Common Bile Duct, Endoscopic
0FL98ZZ	Occlusion of Common Bile Duct, Endoscopic
0FL98DZ	Occlusion of Common Bile Duct with Intraluminal Device, Endoscopic
0FT98ZZ	Resection of Common Bile Duct, Endoscopic
0FV98ZZ	Restriction of Common Bile Duct, Endoscopic
0FV98DZ	Restriction of Common Bile Duct with Intraluminal Device, Endoscopic
0FN98ZZ	Release Common Bile Duct, Endoscopic
0FQ98ZZ	Repair Common Bile Duct, Endoscopic
0F788DZ	Dilation of Cystic Duct with Intraluminal Device, Endoscopic
0F788ZZ	Dilation of Cystic Duct, Endoscopic
0F5D8ZZ	Destruction of Pancreatic Duct, Endoscopic
0F7D8DZ	Dilation of Pancreatic Duct with Intraluminal Device, Endoscopic
0F7D8ZZ	Dilation of Pancreatic Duct, Endoscopic
0F7F8DZ	Dilation of Access Pancreatic Duct with Intraluminal Device, Endoscopic
0F7F8ZZ	Dilation of Accessory Pancreatic Duct, Endoscopic
0F9D8ZX	Drainage of Pancreatic Duct, Endoscopic, Diagnostic
0F9D8ZZ	Drainage of Pancreatic Duct, Endoscopic
0FBD8ZX	Excision of Pancreatic Duct, Endoscopic, Diagnostic
0FBD8ZZ	Excision of Pancreatic Duct, Endoscopic
0FFD8ZZ	Fragmentation in Pancreatic Duct, Endoscopic
0FLD8ZZ	Occlusion of Pancreatic Duct, Endoscopic
0FNF8ZZ	Release Accessory Pancreatic Duct, Endoscopic

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Cholangioscopy Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0FQF8ZZ	Repair Accessory Pancreatic Duct, Endoscopic
0FTD8ZZ	Resection of Pancreatic Duct, Endoscopic
0FVD8ZZ	Restriction of Pancreatic Duct, Endoscopic
0FVF8DZ	Restriction of Access Pancreatic Duct with Intraluminal Device, Endoscopic
0FPD80Z	Removal of Drainage Device from Pancreatic Duct, Endoscopic
0FPD81Z	Removal of Radioactive Element from Pancreatic Duct, Endoscopic
0FPD82Z	Removal of Monitoring Device from Pancreatic Duct, Endoscopic
0FPD83Z	Removal of Infusion Device from Pancreatic Duct, Endoscopic
0FPD87Z	Removal of Autologous Tissue Substitute from Pancreatic Duct, Endoscopic
0FPD8CZ	Removal of Extraluminal Device from Pancreatic Duct, Endoscopic
0FPD8DZ	Removal of Intraluminal Device from Pancreatic Duct, Endoscopic
0FPD8JZ	Removal of Synthetic Substitute from Pancreatic Duct, Endoscopic
0FPD8KZ	Removal of Nonautologous Tissue Substitute from Pancreatic Duct, Endoscopic
0FPD8YZ	Removal of Other Device from Pancreatic Duct, Endoscopic
0FWD80Z	Revision of Drainage Device in Pancreatic Duct, Endoscopic
0FWD82Z	Revision of Monitoring Device in Pancreatic Duct, Endoscopic
0FWD83Z	Revision of Infusion Device in Pancreatic Duct, Endoscopic
0FWD8CZ	Revision of Extraluminal Device in Pancreatic Duct, Endoscopic
0FWD8DZ	Revision of Intraluminal Device in Pancreatic Duct, Endoscopic
0FWD8JZ	Revision of Synthetic Substitute in Pancreatic Duct, Endoscopic
0FHD8DZ	Insertion of Intraluminal Device into Pancreatic Duct, Endoscopic
0FND8ZZ	Release Pancreatic Duct, Endoscopic
0FQD8ZZ	Repair Pancreatic Duct, Endoscopic
0FNC8ZZ	Release Ampulla of Vater, Endoscopic
0FQC8ZZ	Repair Ampulla of Vater, Endoscopic
0F5C8ZZ	Destruction of Ampulla of Vater, Endoscopic
0F7C8DZ	Dilation of Ampulla of Vater with Intraluminal Device, Endoscopic
0F7C8ZZ	Dilation of Ampulla of Vater, Endoscopic
0F9C80Z	Drainage of Ampulla of Vater with Drainage Device, Endoscopic
0F9C8ZZ	Drainage of Ampulla of Vater, Endoscopic
0FBC8ZZ	Excision of Ampulla of Vater, Endoscopic
0FFC8ZZ	Fragmentation in Ampulla of Vater, Endoscopic
0FLC8DZ	Occlusion of Ampulla of Vater with Intraluminal Device, Endoscopic
0FLC8ZZ	Occlusion of Ampulla of Vater, Endoscopic
0FTC8ZZ	Resection of Ampulla of Vater, Endoscopic
0FVC8DZ	Restriction of Ampulla of Vater with Intraluminal Device, Endoscopic
0FVC8ZZ	Restriction of Ampulla of Vater, Endoscopic
0FCC8ZZ	Extirpation of Matter from Ampulla of Vater, Endoscopic
0F768DZ	Dilation of Left Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F778DZ	Dilation of Common Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F778ZZ	Dilation of Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0F788DZ	Dilation of Cystic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0FCD8ZZ	Extirpation of Matter from Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FCF8ZZ	Extirpation of Matter from Accessory Pancreatic Duct, Via Natural or Artificial Opening Endoscopic

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Cholangioscopy Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
0FC58ZZ	Extirpation of Matter from Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC68ZZ	Extirpation of Matter from Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC78ZZ	Extirpation of Matter from Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC88ZZ	Extirpation of Matter from Cystic Duct, Via Natural or Artificial Opening Endoscopic

Medicare Hospital Inpatient Payment

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.

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC[5])	$10,622
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC[5])	$7,046
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,495
438	Disorders of pancreas except malignancy with MCC[5]	$10,254
439	Disorders of pancreas except malignancy with CC[5]	$5,303
440	Disorders of pancreas except malignancy without CC/MCC	$3,853
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC[5]	$11,582
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC[5]	$5,842
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$4,258
444	Disorders of the biliary tract with MCC[5]	$10,178
445	Disorders of the biliary tract with CC[5]	$6,725
446	Disorders of the biliary tract without CC/MCC	$5,087

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Dilation Procedural Reimbursement 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

		RVUs			2020 Medicare National Average Payment			
					Physician‡,2		Facility3	
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	5.28	NA	$191	$2,999†	$1,306
43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	3.40	NA	5.56	NA	$201	$1,557†	$663
43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)	2.00	26.53	3.40	$1,039	$123	$1,557†	$663
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	4.07	NA	6.62	NA	$239	$1,557†	$663
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.67	28.07	4.42	$1,121	$160	$1,557†	$663
44381	Ileoscopy, through stoma; with transendoscopic balloon dilation	1.38	26.34	2.40	$1,006	$87	$1,557†	$663
44405	Colonoscopy through stoma; with transendoscopic balloon dilation	3.23	12.33	5.28	$574	$191	$1,004	$507
45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	1.25	11.51	2.24	$466	$81	$1,004	$507
45386	Colonoscopy, flexible; with transendoscopic balloon dilation	3.77	13.20	6.11	$628	$221	$1,004	$507
Balloon or Rigid								
43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire	3.31	NA	5.63	NA	$203	$2,999†	$1,306
43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	4.63	29.72	7.48	$1,263	$270	$1,557†	$663
43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire	2.24	7.63	3.75	$368	$135	$1,557†	$663
43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)	3.08	13.30	5.08	$606	$183	$1,557†	$663
43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	2.91	7.84	4.78	$400	$173	$786	$397
45303	Proctosigmoidoscopy, rigid; with dilation (eg, balloon, guide wire, bougie)	1.40	25.64	2.45	$983	$88	$1,004	$507

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.

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Endoscopic Submucosal Dissection Procedural Reimbursement 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

		RVUs			2020 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
ESD*								
43499	Unlisted procedure, esophagus	NA	NA	NA	NA	NA	$786	N/A
43999	Unlisted procedure, stomach	NA	NA	NA	NA	NA	$786	N/A
44799	Unlisted procedure, small intestine	NA	NA	NA	NA	NA	$786	N/A
45399	Unlisted procedure, colon	NA	NA	NA	NA	NA	$764	N/A
45999	Unlisted procedure, rectum	NA	NA	NA	NA	NA	$764	N/A

*Note: Currently, there are no unique Current Procedural Terminology (CPT) codes for ESD. In the absence of a unique ESD code, providers may bill an unlisted procedure code. Providers should submit a cover letter with the claim that explains the nature of the procedure, equipment required, estimated practice cost, and a comparison of physician work (time, intensity, risk) with other comparable services for which the payer has an established value. Reimbursement information is being provided for illustrative purposes only. Providers are solely responsible for all procedure, coding and billing decisions.

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Endoscopic Ultrasound-Guided Procedural Reimbursement Guide
Select Endoscopy Procedures

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

		RVUs			2020 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	NA	5.75	NA	$208	$1,557[†]	$663
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	6.70	NA	$242	$1,557[†]	$663
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	7.58	NA	$274	$1,557[†]	$663
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	2.96	5.92	4.88	$334	$176	$2,999[†]	$1,306
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	7.60	NA	$274	$1,557[†]	$663
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	7.95	NA	$287	$1,004	$507
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	2.98	NA	4.89	NA	$176	$1,004	$507
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	8.78	NA	$317	$1,004	$507

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.

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

		RVUs			2020 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	11.33	NA	$409	$2,999[†]	$1,968
Stent Retrieval								
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	7.08	5.11	$381	$184	$786	$397
Endoscopic Necrosectomy								
48999	Unlisted procedure, pancreas	NA	NA	NA	NA	NA	$610	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
0F9G80Z	Drainage of Pancreas with Drainage Device, Via Natural or Artificial Opening Endoscopic
0FBG8ZZ	Excision of Pancreas, Via Natural or Artificial Opening Endoscopic

Medicare Hospital Inpatient Payment

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.

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment
405	Pancreas, liver and shunt procedures with MCC	$33,969
406	Pancreas, liver and shunt procedures with CC	$17,468
407	Pancreas, liver and shunt procedures without CC/MCC	$13,058
438	Disorders of pancreas except malignancy with MCC	$10,254
439	Disorders of pancreas except malignancy with CC	$5,303
440	Disorders of pancreas except malignancy without CC/MCC	$3,853

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

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

		RVUs			2020 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	5.80	NA	$209	$1,557[†]	$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[†]	$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[†]	$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[†]	$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[†]	$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

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 26 for footnotes

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Hemostasis Procedural Reimbursement 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

		RVUs			2020 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	14.48	4.75	$638	$171	$1,557[†]	$663
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	3.56	14.74	5.79	$675	$209	$1,557[†]	$663
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	6.93	NA	$250	$1,557[†]	$663
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	11.10	NA	$401	$1,557[†]	$663
44391	Colonoscopy through stoma; with control of bleeding, any method	4.12	14.69	6.65	$695	$240	$1,004	$507
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	2.00	12.80	3.38	$542	$122	$1,004	$507
45382	Colonoscopy, flexible; with control of bleeding, any method	4.66	14.85	7.48	$723	$270	$1,004	$507
Ligation								
43205	Esophagoscopy, flexible, transoral; with band ligation of esophageal varices	2.44	NA	4.07	NA	$147	$1,557[†]	$663
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	4.40	NA	7.08	NA	$256	$1,557[†]	$663
45350	Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	1.68	15.91	2.92	$643	$105	$1,004	$507
45398	Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)	4.20	17.55	6.83	$807	$246	$1,004	$507
46221	Hemorrhoidectomy, internal, by rubber band ligation(s)	2.36	5.16	5.52	$283	$199	$764	$186
Injection								
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	2.79	NA	4.86	NA	$175	$1,557[†]	$663
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	1.72	4.93	2.98	$249	$108	$1,557[†]	$663
43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices	2.33	NA	3.90	NA	$141	$1,557[†]	$663
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	2.39	7.99	3.99	$384	$144	$786	$397
43243	Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices	4.27	NA	6.85	NA	$247	$1,557[†]	$663
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	3.02	7.98	4.97	$411	$179	$1,004	$507
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	1.04	6.41	1.91	$274	$69	$764	$386
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	3.56	8.07	5.79	$435	$209	$1,004	$507

Medicare Hospital Inpatient Payment

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.

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
377	GI Hemorrhage with Major Complication or Comorbidity (MCC[5])	$11,078
378	GI Hemorrhage with Complication or Comorbidity (CC[5])	$6,184
379	GI Hemorrhage without CC/MCC	$4,041
432	Cirrhosis & alcoholic hepatitis with MCC[5]	$11,413
433	Cirrhosis & alcoholic hepatitis with CC[5]	$6,459
434	Cirrhosis & alcoholic hepatitis without CC/MCC	$4,005

Please refer to page 26 for footnotes

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Polypectomy Procedural Reimbursement 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

		RVUs			2020 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	8.62	3.86	$404	$139	$1,557†	$663
43250	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	2.97	8.94	4.94	$446	$178	$1,557†	$663
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	5.24	NA	$189	$1,557†	$663
44392	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	3.53	6.52	5.78	$382	$209	$1,004	$507
45308	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1.30	3.63	2.44	$189	$88	$2,344†	$1,100
45333	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	1.55	7.15	2.71	$322	$98	$764	$386
45384	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps	4.07	8.90	6.60	$488	$238	$1,004	$507
Snare								
43217	Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.80	8.33	4.62	$413	$167	$1,557†	$663
43251	Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	3.47	9.71	5.66	$490	$204	$1,557†	$663
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	5.90	NA	$213	$1,557†	$663
44394	Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.03	7.57	6.52	$437	$235	$1,004	$507
45309	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	1.40	3.69	2.60	$196	$94	$1,004	$507
45338	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2.05	5.76	3.47	$291	$125	$1,004	$507
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.57	7.58	7.35	$457	$265	$1,004	$507
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	3.81	3.08	$214	$111	$1,004	$507
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	15.91	5.70	$715	$206	$2,999†	$1,306
Foreign Body Removal								
43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)	3.51	NA	5.55	NA	$200	$1,557†	$663
43215	Esophagoscopy, flexible, transoral; with removal of foreign body(s)	2.44	8.16	4.08	$395	$147	$1,557†	$663
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	7.08	5.11	$381	$184	$786	$397
44363	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body(s)	3.39	NA	5.54	NA	$200	$1,557†	$663
45307	Proctosigmoidoscopy, rigid; with removal of foreign body	1.60	3.47	2.81	$192	$101	$2,344†	$1,100
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	1.76	5.54	3.04	$272	$110	$1,004	$507
45379	Colonoscopy, flexible; with removal of foreign body(s)	4.28	7.36	6.91	$438	$249	$1,004	$507
Endoscopic Mucosal Resection								
43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	4.20	NA	6.77	NA	$244	$1,557†	$663
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	4.87	NA	7.80	NA	$281	$1,557†	$663
44403	Colonoscopy through stoma; with endoscopic mucosal resection	5.50	NA	8.77	NA	$317	$1,004	$507
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	3.52	NA	5.73	NA	$207	$2,344†	$1,100
45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.04	NA	9.59	NA	$346	$2,344†	$1,100

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 26 for footnotes
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Stenting Procedural Reimbursement Guide

Select Endoscopy Procedures

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

		RVUs			2020 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	13.36	NA	$482	$4,781†	$1,961
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	6.86	NA	10.86	NA	$392	$2,999†	$1,306
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	13.90	NA	$502	$4,781†	$1,961
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	5.48	NA	$198	$4,781†	$3,125
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.92	NA	6.29	NA	$227	$4,781†	$3,165
Colonic and Duodenal Stenting								
43266	Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	3.92	NA	6.29	NA	$227	$4,781†	$3,165
44370	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with transendoscopic stent placement (includes predilation)	4.69	NA	7.69	NA	$278	$4,781†	$3,169
44379	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with transendoscopic stent placement (includes predilation)	7.36	NA	11.80	NA	$426	$4,781†	$1,961
44384	Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	2.85	NA	4.44	NA	$160	$2,999†	$1,306
44402	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)	4.70	NA	7.56	NA	$273	$4,781†	$2,944
45327	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)	1.90	NA	3.41	NA	$123	$4,781†	$2,537
45347	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	2.72	NA	4.44	NA	$160	$4,781†	$3,247
45389	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	5.24	NA	8.37	NA	$302	$4,781†	$3,133
Foreign Body Removal (Stent Removal)								
43194	Esophagoscopy, rigid, transoral; with removal of foreign body(s)	3.51	NA	5.55	NA	$200	$1,557†	$663
43215	Esophagoscopy, flexible, transoral; with removal of foreign body(s)	2.44	8.16	4.08	$395	$147	$1,557†	$663
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)	3.11	7.08	5.11	$381	$184	$786	$397
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	6.86	NA	10.86	NA	$392	$2,999†	$1,306
44363	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with removal of foreign body(s)	3.39	NA	5.54	NA	$200	$1,557†	$663
45307	Proctosigmoidoscopy, rigid; with removal of foreign body	1.60	3.47	2.81	$192	$101	$2,344†	$1,100
45332	Sigmoidoscopy, flexible; with removal of foreign body(s)	1.76	5.54	3.04	$272	$110	$1,004	$507
45379	Colonoscopy, flexible; with removal of foreign body(s)	4.28	7.36	6.91	$438	$249	$1,004	$507

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Stenting Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures

ICD-10 PCS Code	ICD-10 PCS Description
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
0F778DZ	Dilation of Common Hepatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F778ZZ	Dilation of Common Hepatic Duct, 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
0F7C8DZ	Dilation of Ampulla of Vater with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F7D8DZ	Dilation of Pancreatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0F7F8DZ	Dilation of Accessory Pancreatic Duct with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0FHB8DZ	Insertion of Intraluminal Device into Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0FHD8DZ	Insertion of Intraluminal Device into Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FC58ZZ	Extirpation of Matter from Right Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC68ZZ	Extirpation of Matter from Left Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC78ZZ	Extirpation of Matter from Common Hepatic Duct, Via Natural or Artificial Opening Endoscopic
0FC88ZZ	Extirpation of Matter from Cystic Duct, Via Natural or Artificial Opening Endoscopic
0FC98ZZ	Extirpation of Matter from Common Bile Duct, Via Natural or Artificial Opening Endoscopic
0FCC8ZZ	Extirpation of Matter from Ampulla of Vater, Via Natural or Artificial Opening Endoscopic
0FCD8ZZ	Extirpation of Matter from Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FCF8ZZ	Extirpation of Matter from Accessory Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0FPB8DZ	Removal of Intraluminal Device from Hepatobiliary Duct, Via Natural or Artificial Opening Endoscopic
0FPD8DZ	Removal of Intraluminal Device from Pancreatic Duct, Via Natural or Artificial Opening Endoscopic
0D718DZ	Dilation of Upper Esophagus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D728DZ	Dilation of Middle Esophagus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D738DZ	Dilation of Lower Esophagus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D748DZ	Dilation of Esophagogastric Junction with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D758DZ	Dilation of Esophagus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0DH58DZ	Insertion of Intraluminal Device into Esophagus, Via Natural or Artificial Opening Endoscopic
0D768DZ	Dilation of Stomach with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D778DZ	Dilation of Stomach, Pylorus with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0D798DZ	Dilation of Duodenum with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0DH68DZ	Insertion of Intraluminal Device into Stomach, Via Natural or Artificial Opening Endoscopic
0DH98DZ	Insertion of Intraluminal Device into Duodenum, Via Natural or Artificial Opening Endoscopic
0DH88DZ	Insertion of Intraluminal Device into Small Intestine, 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
0DC18ZZ	Extirpation of Matter from Upper Esophagus, Via Natural or Artificial Opening Endoscopic
0DC28ZZ	Extirpation of Matter from Middle Esophagus, Via Natural or Artificial Opening Endoscopic
0DC38ZZ	Extirpation of Matter from Lower Esophagus, Via Natural or Artificial Opening Endoscopic
0DC58ZZ	Extirpation of Matter from Esophagus, Via Natural or Artificial Opening Endoscopic
0DC48ZZ	Extirpation of Matter from Esophagogastric Junction, Via Natural or Artificial Opening Endoscopic
0DC68ZZ	Extirpation of Matter from Stomach, Via Natural or Artificial Opening Endoscopic
0DC78ZZ	Extirpation of Matter from Stomach, Pylorus, Via Natural or Artificial Opening Endoscopic
0DC88ZZ	Extirpation of Matter from Small Intestine, Via Natural or Artificial Opening Endoscopic

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Stenting Procedural Reimbursement Guide (Continued)

Medicare Hospital Inpatient Coding - Select Procedures (Continued)

ICD-10 PCS Code	ICD-10 PCS Description
0DC98ZZ	Extirpation of Matter from Duodenum, Via Natural or Artificial Opening Endoscopic
0DCA8ZZ	Extirpation of Matter from Jejunum, Via Natural or Artificial Opening Endoscopic
0DCN8ZZ	Extirpation of Matter from Sigmoid Colon, Via Natural or Artificial Opening Endoscopic
0DCP8ZZ	Extirpation of Matter from Rectum, Via Natural or Artificial Opening Endoscopic
0DCC8ZZ	Extirpation of Matter from Ileocecal Valve, Via Natural or Artificial Opening Endoscopic
0DCE8ZZ	Extirpation of Matter from Large Intestine, Via Natural or Artificial Opening Endoscopic
0DCF8ZZ	Extirpation of Matter from Right Large Intestine, Via Natural or Artificial Opening Endoscopic
0DCG8ZZ	Extirpation of Matter from Left Large Intestine, Via Natural or Artificial Opening Endoscopic
0DCH8ZZ	Extirpation of Matter from Cecum, Via Natural or Artificial Opening Endoscopic
0DCK8ZZ	Extirpation of Matter from Ascending Colon, Via Natural or Artificial Opening Endoscopic
0DCL8ZZ	Extirpation of Matter from Transverse Colon, Via Natural or Artificial Opening Endoscopic
0DCM8ZZ	Extirpation of Matter from Descending Colon, Via Natural or Artificial Opening Endoscopic

Medicare Hospital Inpatient Payment

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.

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
329	Major Small & Large Bowel Procedures with Major Complication or Comorbidity (MCC[5])	$30,714
330	Major Small & Large Bowel Procedures with Complication or Comorbidity (CC[5])	$15,815
331	Major Small & Large Bowel Procedures without CC/MCC	$10,573
374	Digestive Malignancy with MCC[5]	$12,502
375	Digestive Malignancy with CC[5]	$7,556
376	Digestive Malignancy without CC/MCC	$6,267
391	Esophagitis, Gastroenteritis, & Misc Digest Disorders with MCC[5]	$7,730
392	Esophagitis, Gastroenteritis, & Misc Digest Disorders without MCC[5]	$4,766
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC[5])	$10,622
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC[5])	$7,046
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,495
438	Disorders of pancreas except malignancy with MCC[5]	$10,254
439	Disorders of pancreas except malignancy with CC[5]	$5,303
440	Disorders of pancreas except malignancy without CC/MCC	$3,853
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC[5]	$11,582
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC[5]	$5,842
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$4,258
444	Disorders of the biliary tract with MCC[5]	$10,178
445	Disorders of the biliary tract with CC[5]	$6,725
446	Disorders of the biliary tract without CC/MCC	$5,087

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Medicare Hospital Outpatient Facility Payment

APC	Description	2020 Medicare National Average Payment[3]
5301	Level 1 Upper GI Procedures	$786
5302	Level 2 Upper GI Procedures	$1,557†
5303	Level 3 Upper GI Procedures	$2,999†
5311	Level 1 Lower GI Procedures	$764
5312	Level 2 Lower GI Procedures	$1,004
5313	Level 3 Lower GI Procedures	$2,344†
5331	Complex GI Procedures	$4,781†

† 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

To determine whether there are relevant C-codes for any Boston Scientific products, please visit our C-code finder at http://www.bostonscientific.com/en-US/reimbursement/ccode-finder.html.

C-Codes are tracking codes established by the Centers for Medicare & Medicaid Services (CMS) to assist Medicare in establishing future APC payment rates. C-Codes only apply to Medicare hospital outpatient claims. They do not trigger additional payment to the facility today.

It is very important that hospitals report C-Codes as well as the associated device costs. This will help inform and potentially increase future outpatient hospital payment rates.

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 guidewires used in GI procedures: Dreamwire™ Guidewire, Hydra Jagwire™ Guidewire, Jagwire™ Guidewire, Jagwire™ Revolution, 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™ Single-Use 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™ Biliary Stent with Introducer Kits1
		RX Biliary Stents with RX Delivery System™

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 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.

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 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

4 National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($6,258.96). Source: October 2019 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, 2020.

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See important information about the uses and limitations of this document on pages 2 and 3