

2020 Coding & Payment Quick Reference

Select Hemostasis/Clipping 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 Hemostasis 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® Code¹	Code Description	RVUs			Physician*²			
		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	\$1,557¹	\$663
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	3.56	14.74	5.79	\$675	\$209	\$1,557¹	\$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	\$1,557¹	\$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	\$1,557¹	\$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	\$1,557¹	\$663
43244	Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices	4.40	NA	7.08	NA	\$256	\$1,557¹	\$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

See important notes on the uses and limitations of this information on page 3.

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CPT® Code ¹	Code Description	Work	RVUs			2020 Medicare National Average Payment		
			Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Injection								
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	2.79	NA	4.86	NA	\$175	\$1,557 ¹	\$663
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	1.72	4.93	2.98	\$249	\$108	\$1,557 ¹	\$663
43204	Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices	2.33	NA	3.90	NA	\$141	\$1,557 ¹	\$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 ¹	\$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

Clipping**Endoscopic Marking**

There are no specific CPT® Codes for endoscopic tissue marking with a clip; the procedure defaults to an unlisted procedure code for the area in which the clip is being placed (e.g., unlisted procedure code for the intestine: 44799). Average payments for unlisted procedure codes reflect payment for all unlisted procedures. They would not accurately represent endoscopic marking procedure payments and therefore are not listed.

Closure

If a clip is used as a method of closure secondary to another procedure then it would be considered inherent in the primary procedure. If the clip is used during a separate event (session) then, it is separately billable. For control of bleeding from a previous polypectomy site, the application of the clip would be considered control of bleeding for the area in which the clip was placed. For closure of a perforation/fistula, the application of the clip would be an unlisted procedure code for the area in which the clip is placed. Average payments for unlisted procedure codes reflect payment for all unlisted procedures. It would not be an accurate representation of closure procedure payment and therefore is not listed.

Anchoring of Jejunal Feeding Tube

There is no separate coding for use of the clip; clip placement would be inherent in the primary procedure coding for attachment of the tube (see codes in the "Enteral Feeding Coding and Payment Quick Reference Guide").

C-Code Information

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

Medicare Hospital Inpatient Payment Rates Effective October 1, 2019 - September 30, 2020

Medicare Severity Diagnosis Related Groups (MS-DRGs) 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-DRGs resulting from inpatient hemostasis procedures may include (but are not limited to):

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

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

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.

† 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 OPPI 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.

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) 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.

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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