2021 Coding & Payment Quick Reference

Select Laparoscopic Cholecystectomy Procedures with and without Common Bile Duct Exploration (CBDE)

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 Laparoscopic Cholecystectomy with and without Common Bile Duct Exploration (CBDE) procedures and are referenced throughout this guide.

All rates shown are 2021 Medicare 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.[6]

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, including the SpyGlass™ Discover Digital Catheter.

Medicare Physician Payments

		2021 Medicare National Average Payment		
		RVUs		Physician[‡,2]
CPT® Code[1]	Code Description	Work	Total Facility	In-Facility
Laparoscopic Cholecystectomy				
47562	Laparoscopy, surgical; cholecystectomy	10.47	19.54	$682
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	11.47	21.26	$742
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	18.00	33.09	$1,155
Choledochoscopy (Add-on Code)				
+47550	Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)	3.02	4.86	$170

+CPT Code 47550 is an Add-On code and must be reported with a primary procedure. CMS categorizes this code as a "Type II Add-on Code". Type II Add-on codes do not have a defined set of primary procedure codes. CMS indicates primary procedure are "Contractor Defined" and may therefore vary among Medicare Administrative Carriers (MACs) and private payers.

Medicare Hospital Inpatient Facility Coding - Select Procedures

ICD-10-PCS Code	Description
0FJB4ZZ	Inspection of Hepatobiliary Duct, Percutaneous Endoscopic Approach
0FT44ZZ	Resection of Gallbladder, Percutaneous Endoscopic Approach
BF10YZZ	Fluoroscopy of Bile Ducts using Other Contrast
BF50200	Other Imaging of Bile Ducts using Fluorescing Agent, Indocyanine Green Dye, Intraoperative
BF502Z0	Other Imaging of Bile Ducts using Fluorescing Agent, Intraoperative
BF52200	Other Imaging of Gallbladder using Fluorescing Agent, Indocyanine Green Dye, Intraoperative
BF522Z0	Other Imaging of Gallbladder using Fluorescing Agent, Intraoperative
BF53200	Other Imaging of Gallbladder and Bile Ducts using Fluorescing Agent, Indocyanine Green Dye, Intraoperative
BF532Z0	Other Imaging of Gallbladder and Bile Ducts using Fluorescing Agent, Intraoperative

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

Effective: 1JAN2021
Expires: 31DEC2021
MS-DRG Rates Expire: 30SEP2021
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Medicare Hospital Inpatient Facility Payment

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 laparoscopic cholecystectomy with common bile duct exploration procedures may include (but are not limited to):

MS-DRG	Description	Hospital Inpatient Medicare National Average Payment[4]
411	Cholecystectomy with C.D.E. with MCC	$24,118
412	Cholecystectomy with C.D.E. with CC	$14,627
413	Cholecystectomy with C.D.E. without CC/MCC	$11,128
417	Laparoscopic Cholecystectomy without C.D.E. with MCC	$15,577
418	Laparoscopic Cholecystectomy without C.D.E. with CC	$10,850
419	Laparoscopic Cholecystectomy without C.D.E. without CC/MCC	$8,453

Note: Laparoscopic cholecystectomy procedures, when performed with common bile duct exploration (CBDE) typically map to MS-DRGs 411-413. Laparoscopic cholecystectomy procedures without common bile duct exploration (CBDE) typically map to MS-DRGs 417-419. Medical documentation and proper ICD-10-PCS code selection is important to ensure appropriate MS-DRG assignment.

Hospital Outpatient and ASC Coding and Payment

CPT® Code[1]	Code Description	2021 Medicare National Average Payment Facility[3] Hospital Outpatient	ASC
Laparoscopic Cholecystectomy			
47562	Laparoscopy, surgical; cholecystectomy	$5,060†	$2,318
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	$5,060†	$2,318
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	$5,060†	$2,318
Choledochoscopy (Add-on Code)			
+47550	Biliary endoscopy, intraoperative (choledochoscopy) (List separately in addition to code for primary procedure)	N/A (Included in C-APC payment)	

+CPT Code 47550 is an Add-On code and must be reported with a primary procedure. CMS categorizes this code as a "Type II Add-on Code". Type II Add-on codes do not have a defined set of primary procedure codes. CMS indicates primary procedure are "Contractor Defined" and may therefore vary among Medicare Administrative Carriers (MACs) and private payers.

C-Code Information

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. 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.

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

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 December 2020 but is subject to change without notice. Rates for services are effective January 1, 2021.

† 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 2021 National Average Medicare physician payment rates have been calculated using a 2021 conversion factor of $34.8931. Rates subject to change.

1. Current Procedural Rate (CPT) 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
2. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule - December 2020 release, RVU21A file https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f.
3. December 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 ($6,427.52) October 2020 Federal Register.
5. The patient's medical record must support the existence and treatment of the complication or co-morbidity.
6. 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 March 31, 2021.

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