Boston Scientific
Advancing science for life™

2023 Coding & Payment Quick Reference

Endoluminal Surgery (ELS)

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.

Endoscopic Mucosal Resection (EMR) Medicare Hospital Outpatient Coding & Payment

						2023 Medicare National Average Payment			
			RVUs			Physician‡, 2		Facility3	
APC	CPT® Code1	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Endoscopic Mucosal Resection (EMR)									
5302†	43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	4.20	NA	6.89	NA	$233	$1,742	$752
5302†	43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	4.87	NA	7.91	NA	$268	$1,742	$752
5312	44403	Colonoscopy through stoma; with endoscopic mucosal resection	5.50	NA	8.92	NA	$302	$1,083	$564
5313†	45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	3.52	NA	5.82	NA	$197	$2,569	$1,235
5313†	45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.04	NA	9.74	NA	$330	$2,569	$1,235

Endoscopic Submucosal Dissection (ESD) Medicare Hospital Outpatient Coding & Payment

The Centers for Medicare & Medicaid Services (CMS) has established a new HCPCS Code describing the Endoscopic Submucosal Dissection (ESD) procedure during an endoscopy or colonoscopy. Effective October 1, 2021, HCPCS Code C9779 may be used by hospitals to report ESD procedures performed in the outpatient setting.

APC	HCPCS Code	Description	2023 Medicare National Average Payment3
5303†	C9779	Endoscopic submucosal dissection (ESD), including endoscopy or colonoscopy, mucosal closure, when performed	$3,261

ESD Medicare Physician Coding & Payment

Currently, there is no unique Current Procedural Terminology (CPT) codes for ESD. In the absence of a unique ESD code, physicians may bill an unlisted procedure code. Physicians 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.

						2023 Medicare National Average Payment	
				RVUs		Physician‡, 2	
APC	CPT® Code1	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility
ESD							
5301	43499	Unlisted procedure, esophagus	NA	NA	NA	NA	NA
5301	43999	Unlisted procedure, stomach	NA	NA	NA	NA	NA
5301	44799	Unlisted procedure, small intestine	NA	NA	NA	NA	NA
5301	45399	Unlisted procedure, colon	NA	NA	NA	NA	NA
5301	45999	Unlisted procedure, rectum	NA	NA	NA	NA	NA

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

POEM Medicare Hospital Outpatient Coding & Payment

The American Medical Association (AMA) has established a new CPT Code describing the Peroral Endoscopic Myotomy (POEM) procedure. Effective January 1, 2022, CPT Code 43497 may be used to report POEM procedures.

			RVUs			2023 Medicare National Average Payment			
						Physician‡, 2		Facility3	
APC	CPT® Code1	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Peroral Endoscopic Myotomy (POEM)									
5303†	43497	Lower esophageal myotomy, transoral (i.e., Peroral endoscopic myotomy [POEM])	13.29	NA	23.52	NA	$797	$3,261	N/A

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 January 2023 but is subject to change without notice. Rates for services are effective January 1, 2023.

† Comprehensive APCs (C-APCs): CMS implemented their C-APC policy with the goal of identifying certain high-cost device-related outpatient procedures (formerly "device intensive" APCs). CMS identifies 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. Certain exceptions are defined under CMS's C-APC "complexity adjustment" policy and can be found in the OPPS Addenda files (Addendum J).

‡ The 2023 National Average Medicare physician payment rates have been calculated using a 2023 conversion factor of $33.8872. 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.

1. Current Procedural Rate (CPT) 2022 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. Centers for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2023 release CMS-1770-F | CMS.
3. Center for Medicare and Medicaid Services. CMS Hospital Outpatient and Ambulatory Surgery Center Payment Schedules – January 2023 release, CMS-1772-FC | CMS.

Effective: 1JAN2023
Expires: 31DEC2023
MS-DRG Rates Expire: 30SEP2023
ENDO-1273002-AB

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.

©2023 Boston Scientific Corporation or its affiliates. All rights reserved. All trademarks are the property of their respective owners.