Medtronic

Engineering the extraordinary

2024 Billing and Coding Guide

Gastrointestinal and hepatology

Overview

This guide is intended to aid providers in appropriate procedure code selection for gastrointestinal and hepatology procedures. The document reflects applicable and commonly billed procedure codes as well as the unadjusted national Medicare average rates assigned to the CPT®[1] code.

Instructions for use:

- New tools can be found in the New for 2024 section.
- Code descriptions and details of code reporting requirements and/or guidance, as well as Physician, Hospital Outpatient, and/or Ambulatory Surgery Center (ASC) rates, can be found in the Coding & Reimbursement section.
- Details surrounding specialized coding and reimbursement information can be found in FAQ and resources section.
- This document is not all-inclusive, nor does it replace advice from your coding and compliance departments and/or CPT®[1] coding manuals.

Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules and regulations. The provider has the responsibility to determine medical necessity and to submit appropriate codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists and/or legal counsel for interpretation of coding, coverage and payment policies. This document provides assistance for FDA approved or cleared indications. Where reimbursement is sought for use of a product that may be inconsistent with, or not expressly specified in, the FDA cleared or approved labeling (e.g., instructions for use, operator's manual or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.

New for 2024

New Tool

Medtronic C-Code Finder

Launching January 2024, we will have a new tool specifically designed to access applicable commonly used C-codes as it relates to Medtronic products. Medicare provides C-codes, a type of HCPCS[2] II code, for hospital use in billing Medicare for some medical devices and supplies in the hospital outpatient setting. The C-code finder can be accessed at www.medtronic.com/c-code or by using the C-code finder button.

C-code Finder

Coding & reimbursement

This section provides Medicare unadjusted national average allowable rates for physician, hospital outpatient, ambulatory surgery, and hospital inpatient settings. The coding information in this section does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. All diagnosis and procedure codes must be supported by clear documentation within the medical record.

Providers may choose to perform multiple procedures during the same encounter. When this occurs, providers must report all procedures and the payment may be subject to packaging rules, multiple procedure reduction, complexity adjustments, or multiple endoscopy reductions.

- HCPCS[2] II codes
- CPT Procedure Codes & Physician[3] Hospital Outpatient[4] and Ambulatory Surgery Center[4] Reimbursement Rates
- Inpatient[5] national unadjusted reimbursement rates and ICD-10 PCS codes[6]

HCPCS[2] II codes

C-code Finder

Level II HCPCS[2] codes are primarily used to report supplies, drugs and implants that are not reported by a CPT® code. HCPCS codes are reported by the physician, hospital or DME provider that purchased the item, device, or supply. Different payers have different payment methods for these items.

C-codes are a series of HCPCS codes that facilities reimbursed under the Medicare Outpatient Prospective Payment System (OPPS) are required to report for eligible items and services. Medicare assigns C-codes to specific devices eligible for pass-through payment. Every year, in the OPPS rule, Medicare publishes a list of CPT®[1] and HCPCS codes that are designated as device-intensive procedures. When reporting procedures on this list, facilities should capture both the CPT®[1] code representing the procedure performed and the C-code representing the device used. Although C-codes only affect Medicare outpatient reimbursement, facilities may also want to report C-codes on inpatient claims if the device is not used exclusively for inpatient procedures. Medicare tracks this information and uses it in its rate-setting process. Non-OPPS facilities may report C-codes at their discretion.

HCPCS[2] code	Description
C9779	Endoscopic submucosal dissection (ESD), including endoscopy or colonoscopy, mucosal closure, when performed
C1726	Catheter, balloon dilation, non-vascular
C1889	Implantable/insertable device, not otherwise classified
C1052	Hemostatic agent, gastrointestinal, topical

Coding & reimbursement

GI diagnostics and therapeutic endoscopy

		Physician[3]			Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Beacon™ EUS delivery system and needles									
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	3.59	NA	$192††	5302	J1	$1,813†	A2	$832
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	$224††	5302	J1	$1,813†	A2	$832
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	$253††	5302	J1	$1,813†	A2	$832
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	$253††	5302	J1	$1,813†	G2	$832

Coding & reimbursement

GI diagnostics and therapeutic endoscopy

		Physician[3]			Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	**Description**	**Work RVU**	**Office rate**	**Facility rate**	**APC**	**Status indicator**	**Rate**	**Payment indicator**	**Rate**
PillCam™ small bowel capsule endoscopy									
91110	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report	2.24	$717	$108	5301	T	$864	NA	NA
PillCam™ COLON 2 system									
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	2.41	$878	$117	5311	T	$871	NA	NA
PillCam™ UGI, Crohn's system, Patency system									
91299	Unlisted diagnostic gastroenterology procedure	X.XX	Carrier priced		5721	S	$149	NA	NA

Coding & reimbursement

GI diagnostics and therapeutic endoscopy

		Physician[3]			Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Eleview®* submucosal injectable composition									
45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.04	NA	$321††	5313	J1	$2,675†	G2	$1,349
44403	Colonoscopy through stoma; with endoscopic mucosal resection	5.50	NA	$293††	5312	T	$1,124	G2	$612
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	3.02	$413††	$166††	5312	T	$1,124	G2	$612
43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	4.20	NA	$227††	5302	J1	$1,813†	G2	$832
43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	4.87	NA	$260††	5302	J1	$1,813†	G2	$832
45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	3.52	NA	$191††	5313	J1	$2,675†	G2	$1,349
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	3.56	$434††	$194††	5312	T	$1,124	A2	$612
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.57	$445††	$245††	5312	T	$1,124	A2	$612
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	2.79	NA	$167	5302	J1	$1,813†	G2	$832
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	1.72	$255	$101	5302	J1	$1,813†	A2	$832

Coding & reimbursement

GI diagnostics and therapeutic endoscopy

		Physician[3]			Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Eleview®* submucosal injectable composition									
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	2.39	$394	$134	5301	T	$864	A2	$470
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	1.04	$285	$65	5311	T	$871	A2	$474
Nexpowder™* endoscopic hemostasis system									
43227	Esophagoscopy, flexible, transoral; with control of bleeding, any method	2.89	$581	$160	5302	J1	$1,813†	A2	$832
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	3.56	$612	$193	5302	J1	$1,813†	A2	$832
C1052	Hemostatic agent, gastrointestinal, topical	NA	NA	NA	NA	N	NA	N1	NA
ProdiGI™ ESD procedures									
43499	Unlisted procedure, esophagus		Carrier priced		5301	T	$864	NA	NA
43999	Unlisted procedure, stomach		Carrier priced		5301	T	$864	NA	NA
44799	Unlisted procedure, small intestine		Carrier priced		5301	T	$864	NA	NA
45399	Unlisted procedure, colon		Carrier priced		5311	T	$871	NA	NA
45999	Unlisted procedure, rectum		Carrier priced		5311	T	$871	NA	NA
C9779	Endoscopic submucosal dissection (ESD), including endoscopy or colonoscopy, mucosal closure, when performed	NA	NA	NA	5303	J1	$3,649†	NA	NA

Coding & reimbursement

Esophageal reflux and motility testing

		Physician[3]			Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	**Description**	**Work RVU**	**Office rate**	**Facility rate**	**APC**	**Status indicator**	**Rate**	**Payment indicator**	**Rate**
Endoflip™ impedance planimetry system									
91040	Esophageal balloon distension study, diagnostic, with provocation when performed	0.97	$507	$47	5723	S	$511	NA	NA
Esoflip™ dilation catheter									
43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)	2.0	$874	$115††	5302	J1	$1,813†	A2	$832
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.67	$1,049	$149††	5302	J1	$1,813†	A2	$832
43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	3.40	NA	$188††	5302	J1	$1,813†	G2	$832
43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	4.07	NA	$222††	5302	J1	$1,813†	G2	$832
Digitrapper™ PH-z testing system									
91034	Esophagus, gastroesophageal reflux test; with nasal catheter pH electrode(s) placement, recording, analysis, and interpretation	0.97	$188	$48	5723	S	$511	NA	NA

Coding & reimbursement

Esophageal reflux and motility testing

		Physician[3]			Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Digitrapper™ PH-z testing system									
91038	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis, interpretation; prolonged (greater than 1 hour, up to 24 hours)	1.10	$396	$53	5723	S	$511	NA	NA
Bravo™ calibration-free reflux testing system									
91035	Esophagus, gastroesophageal reflux test; with mucosal attached telemetry pH electrode placement, recording, analysis and interpretation	1.59	$447	$78	5723	S	$511	Z2	$278
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	2.09	$283	$119††	5301	T	$864	A2	$470
43239	Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple	2.39	$369	$134††	5301	T	$864	A2	$470
ManoScan™ high resolution manometry system									
91010	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report	1.28	$217	$62	5723	S	$511	NA	NA
91037	Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation	0.97	$166	$47	5722	S	$299	NA	NA
91122	Anorectal manometry	1.77	$271	$84	5722	T	$299	NA	NA

Coding & reimbursement

Ablation procedures

		Physician[3]			Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Barrx™ radiofrequency ablation system									
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	$693	$190††	5303	J1	$3,649†,¶	J8	$2,644¶
43270	Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	4.01	$713	$216††	5302	J1	$1,813†	J8	$1074¶
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding any method	3.56	$612	$193	5302	J1	$1,813†	A2	$832
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	2.00	$481	$114	5312	T	$1,124	A2	$612
46615	Anoscopy; with ablation of tumor(s), polyp(s), or other lesion(s) not amendable to removal by hot biopsy forceps, bipolar cautery or snare technique	1.50	$174	$89	5313	J1	$2,675†	A2	$1,349
44366	Small intestinal endoscopy, enteroscopy beyond second portion or duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	4.30	NA	$231	5302	J1	$1,813†	A2	$832
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)	7.02	NA	$370	5302	J1	$1,813†	A2	$832

Coding & reimbursement

Ablation procedures

		Physician[3]			Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
Emprint™ ablation system									
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	14.97	$3,512	$704	5361	J1	$5,498	G2	$2,705
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	20.80	NA	$1,233	5362	J1	$9,808	NA	NA
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	24.56	NA	$1,420			Inpatient only		
47120	Hepatectomy, resection of liver, partial lobectomy	39.01	NA	$2,289			Inpatient only		
47122	Hepatectomy, resection of liver, trisegmentectomy	59.48	NA	$3,340			Inpatient only		
47125	Hepatectomy, resection of liver, total left lobectomy	53.04	NA	$3,009			Inpatient only		
47130	Hepatectomy, resection of liver, total right lobectomy	57.19	NA	$3,229			Inpatient only		
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	2.00	NA	$97	NA	N	NA	NA	NA
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	3.99	NA	$176	NA	N	NA	NA	NA
Cytosponge™* cell collection kit									
88305	Level IV – Surgical Pathology, gross and microscopic examination	0.75	$70	$35	5671	Q1	$52§	NA	NA
88342	Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure	0.70	$104	$33	5672	Q2	$163§	NA	NA

Coding & reimbursement

Lower GI procedures

		Physician[3]			Hospital Outpatient[4]			Ambulatory Surgery[4]	
CPT®[1] code	Description	Work RVU	Office rate	Facility rate	APC	Status indicator	Rate	Payment indicator	Rate
GI Genius™ intelligent endoscopy module									
G0121	Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk	3.26	$334	$179	5311	T	$871	A2	$474
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	3.26	$334	$179	5311	T	$871	A2	$474
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.57	$445††	$245††	5312	T	$1,124	A2	$612
HET™ bipolar system									
46930	Destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)	1.61	$213	$150	5312	T	$1,124	P3	$153

Coding & reimbursement

Inpatient[5] national unadjusted reimbursement rates

Under Medicare's MS-DRG[5] methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. MS-DRGs shown are those typically assigned to the following scenarios when the patient is admitted specifically for the procedure.

Below are commonly used DRGs for ablation procedures, however codes listed below are not exhaustive as other codes may apply.

MS-DRG[5]	Description	Rate
405	Pancreas, Liver and Shunt Procedures W MCC	$38,545
406	Pancreas, Liver and Shunt Procedures W CC	$20,216
407	Pancreas, Liver and Shunt Procedures W/O CC/MCC	$15,060

MCC: Major Complications and/or Comorbidities **CC: Complications and/or Comorbidities**

Coding & reimbursement

ICD-10-PCS[6] procedure codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. Below are commonly used ICD-10-PCS procedure codes associated with liver ablation, however codes listed below are not exhaustive as other codes may apply.

ICD-10-PCS[6] code	Description
0F504ZZ	Destruction of Liver, Percutaneous, Endoscopic Approach
0F514ZZ	Destruction of Right Lobe Liver, Percutaneous, Endoscopic Approach
0F524ZZ	Destruction of Left Lobe Liver, Percutaneous, Endoscopic Approach
0F500ZZ	Destruction of Liver, Open Approach
0F510ZZ	Destruction of Right Lobe Liver, Open Approach
0F520ZZ	Destruction of Left Lobe Liver, Open Approach
0F503ZZ	Destruction of Liver, Percutaneous Approach

Frequently asked questions

GI diagnostics and therapeutic endoscopy

When a GI diagnostic service has a technical and professional component, how should the service be reported?

Providers may choose to report a global charge or the technical (TC) and professional (26) portion of the procedure on separate dates. The decision to split bill the charge or to submit a global charge does not impact the coverage or allowable. For physician interpretation of the test in the facility setting modifier 26 is used to report that only the professional component of the procedure has been provided.

What place of service code should be used when the professional and technical components are performed in different settings?

Per Medicare Claims Processing Manual, section 150, "Many of the diagnostic services, including radiology services, provided by physicians/practitioners contain both a technical component (TC) and a professional component (PC). Often, the PC and TC of diagnostic services are furnished in different settings. As a general policy, the place of service (POS) code assigned by the physician/practitioner for the PC of a diagnostic service shall be the setting in which the beneficiary received the TC service".[7]

How are capsule studies billed when the physician is unable to read the entire study due to poor patient prep?

If the physician feels they are able to visualize part of the small bowel modifier 52 (reduced services) may be appended to CPT®[1] code 91110.[8]

Are both 91010 and 91037 always coded when ManoScan™ is used in a procedure?

Providers should report both codes if motility and impedance tests are performed. 91010 captures the motility portion of the study, and 91037 captures the impedance portion.[10]

For Endoscopic Submucosal Resection (EMR), what components are required to report a CPT®[1] code?

EMR includes three clinical components 1) submucosal injection to lift the lesion; 2) demarcation of the lesion, often by creating a pseudo polyp out of tissue; and 3) endoscopic snare resection. All components must be completed and documented to report an EMR CPT®[1] code. If all are not completed and documented, the submucosal injection and snare polypectomy are reported rather than EMR.[9]

How should the PillCam patency capsule be billed?

"There is not a specific CPT code for PillCam patency capsules. Providers may need to report using an unlisted CPT code. For additional information, please contact us about our Patient Selection Tool.

Frequently asked questions

GI diagnostics and therapeutic endoscopy

What is the appropriate CPT®[1] code(s) to report a colonoscopy with submucosal injection and snare polypectomy?

Both CPT®[1] 45381 and 45385 should be reported for colonoscopy with submucosal injection and snare polypectomy. NCCI (National Correct Coding Initiative) does not currently require the use of a multiple procedure modifier. Multiple procedure reduction payment rules apply.[10]

Is there a dedicated CPT®[1] and/or HCPCS code for reporting Endoscopic Submucosal Dissection (ESD)?

ESD does not currently have CPT®[1] coding assignment and should be reported through the unlisted procedure code based on the anatomic location of the procedure. The payer may require documentation to justify the use, coverage, and payment for the unlisted code. The visualization should be reported separately. Depending on the specific code combination, NCCI may require a multiple-procedure modifier. Multiple procedure reduction payment rules may also apply.[9] Effective 10/1/2021, hospitals may use HCPCS code C9779 to report ESD procedures during an endoscopy or colonoscopy performed in the outpatient setting to Medicare. Facilities are encouraged to verify with their commercial carriers if the HCPCS code is recognized.[10]

Is there a HCPCS code for the Eleview®* composition?

No, there is no dedicated HCPCS code for Eleview®* submucosal injectable composition.

Frequently asked questions

Esophageal reflux and motility testing

Which CPT®[1] code is used to report the Esoflip™ procedure?

The CPT®[1] code selected should be based on both the anatomic area of visualization and dilation as well as the diameter of dilation performed. See page 8 for CPT®[1] coding options.

Does Medicare consider CPT®[1] code 91040 a device intensive procedure?

Yes. CPT®[1] code 91040 was removed from the Medicare OPPS Device-Intensive Procedures list in 2023 but added back in 2024. Medicare reviews cost information to make the determination and provides this information in Addendum P of the Outpatient Perspective Payment System (OPPS) payment file.

Is CPT® [1] code 91034 bundled when billed with CPT® code 91038?

Yes, NCCI bundles CPT®[1] codes 91034 and 91038 when the combined pH and impedance test is completed. CPT® code 91034 is a billable procedure. Medicaid and most commercial payers follow NCCI when processing claims for payment. For impedance testing greater than one hour that does not include a pH measurement the use of CPT ® code 91038 is appropriate.[10]

When CPT®[1] code 91035 is billed on the same date as CPT® codes 43235 or 43239, is a modifier required?

For facility reporting of CPT®[1] codes 43235 and 91035 on the same date National Correct Coding Initiative (NCCI) edits require modifier 59 be amended to CPT® code 43235. The medical record must support the use of modifier 59 to indicate that the EGD is a separate and identifiable procedure from the Bravo™ placement. CPT®[1] code 43239 does not require a modifier when reported at the same encounter as CPT® code 91035. NCCI edits are updated quarterly. Rules should be verified at the time of service. Physician charges are likely not affected by these modifier requirements since their professional services are not typically reported on the same date of service.

Is Bravo eligible for reimbursement as a standalone procedure when placed in the Ambulatory Surgical Center (ASC)?

No. Medicare covers CPT®[1] code 91035 in the ASC setting only as an ancillary service integral to a covered surgical procedure. Both EGD procedures CPT®[1] code 43235 and CPT®[1] code 43239 meet the Medicare definition of a covered surgical procedure. Facility claims submitted for CPT® code 91035 without a covered surgical procedure will likely result in a denial.

Are payers now requiring ASCs to use a modifier TC when reporting Bravo™?

Some payers may require the use of modifier TC on the facility charge for CPT®[1] code 91035. TC is generally a physician service only modifier; providers are encouraged to review payer requirements at the time of benefit verification to determine if required on a case-by-case basis. Use of modifier TC on the facility charge may result in a denial if not specifically mandated by the payer.

Frequently asked questions

Ablation

What is the appropriate procedure code (CPT®[1] code 43229 or 43270) to report when providers use Barrx to remove Barrett's mucosa?

Depending on the depth of the EGD, providers will report the CPT®[1] code which best describes the procedure completed. CPT®[1] code 43229 describes an esophagoscopy with ablation, and CPT®[1] code 43270 describes an esophagogastroduodenoscopy with ablation.

Does Medicare consider CPT®[1] codes 43229 and 43270 device intensive procedures?

Yes, CPT®[1] codes 43229 and 43270 are considered device intensive under the Medicare ASC payment system. Under OPPS (hospital outpatient), only CPT® code 43229 is considered a device intensive procedure. Facilities may use HCPCS code C1889, implantable/insertable device, not otherwise classified, to comply with CMS' claims processing edit.

Are lobectomy and laparoscopic ablation separately reimbursable when performed during the same encounter?

It may be necessary to perform a lobectomy and a laparoscopic ablation at the same surgical encounter. In some circumstances, reimbursement may be reported separately if the encounter is separate and identifiable. Both the facility and the physician may report a charge for the lobectomy and trisegmentectomy procedure and the radiofrequency ablation by appending modifier 59 when the procedure definition of separate and identifiable are met. Providers are encouraged to review their internal guidelines for the addition of this and any other modifiers.

Have any societies published guidance supporting the use of radiofrequency ablation codes to report microwave ablation procedures?

The ACR states that radiofrequency codes should be used for both microwave and radiofrequency ablation. The ACR defines microwave as part of the radiofrequency spectrum and uses a different part of the radiofrequency spectrum to develop heat energy to destroy abnormal tissue.[8]

Is there separate reimbursement for cell collection using the Cytosponge™* cell collection kit?

Medicare and most commercial payers consider specimen collection and handling integral to the office visit and do not provide separate payment for the collection device or for collecting the cells for laboratory evaluation. Payment for the collection of cells using the Cytosponge™ cell collection device is packaged into the payment for the E/M CPT®[1] code.

Frequently asked questions

Lower GI

Are hospital laboratories reimbursed based on the same methodology as independent reference labs?

No. Free-standing independent or physician-owned laboratories can bill globally for the laboratory procedures provided. When billing globally, one payment is made to the laboratory that includes payment for sample processing, preparation, and the pathologist's professional services to interpret the findings and issue a report. Hospital-based laboratories are reimbursed differently than independent reference laboratories. When lab tests are provided in the hospital outpatient setting, the hospital laboratory and the reading pathologist are reimbursed separately. In this scenario, the hospital submits a claim and is reimbursed for the technical preparation and analyses of the sample. The reading pathologist also submits a claim and is reimbursed for their professional services.

Is there a HCPCS code to report for the use of GI Genius™ intelligent endoscopy module?

There is no additional HCPCS code assigned when the GI Genius™ intelligent endoscopy module is added to the procedure.

What is the CPT®[1] code to report tests completed with the GI Genius intelligent endoscopy module?

There is no dedicated CPT®[1] code . The CPT®[1] code is based on the procedure performed.

When HET is combined with other GI procedures during the same encounter is reimbursement impacted?

Providers may choose to perform multiple procedures on the same date of service. Multiple procedure rules may apply. Please consult your internal coding guidelines.

Appendix

Term	Footnote	Definition
Add-on CPT®[1] codes	+	An Add-on Code (AOC) is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An AOC is rarely eligible for payment if it's the only procedure reported by a practitioner.
Carrier priced		Carrier priced codes are not assigned a rate on a national level. Local contractors will determine the reimbursement amount on a case-by-case basis.
Complexity adjustment		The complexity adjustments were implemented by CMS to provide for a payment adjustment when two or more high-cost procedures are performed and paid under Medicare's Hospital Outpatient Comprehensive APC system. To qualify, claims with certain code combinations must meet specific thresholds for both cost and frequency. When these thresholds are met, the code combinations qualify for reassignment to the next highest paying APC.
Comprehensive APC	†	Under its comprehensive APC (C-APC) policy, CMS makes payment for certain costly primary services and all other items and services reported on the hospital outpatient department claim, which CMS considers integral, ancillary, supportive, dependent, and adjunctive to the primary service and representing components of a complete comprehensive service.
Device intensive [11]	¶	The "device intensive" status is assigned to all surgical procedures with an individual HCPCS code-level device offset of greater than 40%. Device intensive procedures are identified in Addendum AA with a payment indicator of XX.
Inpatient only (IPO) list		CMS can define procedures and services for which payment under the outpatient prospective payment system (OPPS) is inappropriate. These codes have a status indicator of "C". Services designated as "inpatient only" are not appropriate to be furnished in a hospital outpatient department. Generally, inpatient only procedures are surgical services that require inpatient care because of the nature of the procedure.
Modifiers[12]	‖	Modifiers are used to supplement the information or adjust the care description to provide extra details concerning a procedure or service. Modifiers help further describe a procedure code without changing its definition. Modifiers are appended to CPT®[1] codes. List of modifiers can be found in the CPT®[1] book.
Multiple endoscopy rule[13]	††	The multiple endoscopy rule requires that you always bundle diagnostic endoscopy with any surgical endoscopy within the same family. The multiple endoscopy rule applies only when the physician performs two or more endoscopies in the same family.
Packaged payment	§	Under OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.
Payment indicator		CMS uses payment indicators to identify each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services' costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment (72 FR 67189-67190).
Status indicator		In the Hospital Outpatient, Status Indicator (SI) shows how a code is handled for payment purposes: C= Inpatient procedures, not paid under OPPS; J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; S = procedure or service not discounted when multiple procedure; Additional details can be found in Addendum D1 of the OPPS rule.
Unlisted codes		Unlisted codes do not have established RVUs under Medicare's Physician Payment System and are typically priced by the contractor after review and individual consideration. Unlisted CPT®[1] codes do not carry a rate assignment from Medicare in the physician office setting. Payment may be available on a case-by-case basis with submission of medical records.
Work relative value unit (RVU)		The Work RVU is a unit of measure that describes the work associated with a physician's procedural services and is factored into the total physician payment. Work RVU is one of three total components on which physician payment is based: physician work RVU, practice expense RVU, and medical malpractice RVU.[7]
w/MCC, w/CC or w/o CC/MCC		In the inpatient setting, w/MCC in MS-DRG titles refers to secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs w/MCC have at least one major secondary complication or comorbidity. Similarly, w/CC in MS-DRG titles refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities, and MS-DRGs w/CC have at least one other (non-major) secondary complication or comorbidity. MS-DRGs w/o CC/MCC have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions were acquired in the hospital during the stay.

Resources

C-code Finder

Medtronic Reimbursement Support is available to assist you with your coding and reimbursement questions. If your coding or reimbursement questions were not answered in this guide, please check out these additional resources:

Visit our website: https://www.medtronic.com/covidien/en-us/support/reimbursement.html

Email us: rs.MedtronicMedicalSurgicalReimbursement@medtronic.com

Ask us about our Letters of Medical Necessity, and Patient Selection Tool templates.

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