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CPT® Codes and Physician Reimbursement

Medicare Part B pays for physician services based upon the Medicare Physician Fee Schedule (MPFS). Fee schedule amounts are calculated according to the Resource-Based Relative Value Scale (RBRVS), which is updated each year. Procedures are reported using CPT® codes. The CPT Manual also provides specific instructions for reporting particular families of codes. Individual payers may also have guidelines and coverage policies regarding certain services. The following table lists the most commonly used codes for biliary diagnostic and therapeutic procedures.

Procedure Codes and Physician Reimbursement for Biliary Stenting

CPT® Code	Description	2018 Work RVUs	2018 Medicare Base Payment Rate[2]	
			Non-Facility	Facility
Surgical Procedures				
47531	Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological S&I; existing access	1.30	$324	$75
47532	New access (e.g., percutaneous transhepatic cholangiogram)	4.25	$815	$222
47538	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (e.g., fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological S&I; existing access	4.75	$4,422	$248
47539	New access, without placement of separate biliary drainage catheter	8.75	$4,900	$449
47540	New access, with placement of separate biliary drainage catheter (e.g., external or internal-external)	9.03	$5,006	$463
47541	Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (e.g., rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological S&I, new access	6.75	$1,201	$349
+47542	Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (e.g., fluoroscopy), and all associated radiological S&I, each duct	2.85	$473	$142

[1] 2018 Current Procedural Terminology (CPT®), ©2016 American Medical Association. CPT® is a registered trademark of the American Medical Association.
[2] The MPFS payment amounts are based upon data elements published by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule [CMS-1677-F] on August 14, 2017, and published in the Federal Register on December 14, 2017, with a conversion factor of $35.99. CMS may make adjustments to any or all of the data inputs from time to time.

Procedure Codes and Physician Reimbursement for Biliary Stenting				
Radiological Imaging				
74328	Endoscopic catheterization of the biliary ductal system, radiological S&I	0.70	N/A	$36
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	0.90	N/A	$47
74363	Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological S&I	0.88	N/A	$44

Note: 2017 revision to CPT codes 47538 – 47540 deleted the phrase "each stent" from the descriptor. Imaging guidance codes are identified as carrier priced (status C) in a non-facility setting.

Ambulatory Surgery Center (ASC) Reimbursement

In general, the ASC payment rate for services is set at approximately 65% of the payment rate for the same service under the HOPPS, with some exceptions.[3] For example, for device-intensive services (where device costs account for more than 50 percent of the total cost of the service), ASCs receive the same payment rate for the device cost as under the HOPPS, with payment for the service portion of the ASC rate calculated at the usual percentage rate of the corresponding OPPS service payment. ASCs will not typically bill separately for these devices.[4]

CMS has assigned APC-based payment rates in an Ambulatory Surgery Center only to surgical procedure codes – CPT® codes in the range 10000 – 69999, plus a few Category III codes, C-codes, and G-codes. Radiology procedures, supplies, and devices are considered ancillary to the surgical procedure; while some are reimbursed additionally, no separate payment is made for cholangiography imaging procedures.

Procedure Codes and ASC Reimbursement for Biliary Stenting		
CPT® Code	**Description**	**2018 Medicare Base Payment Rate[5]**
Surgical Procedures		
47538	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (e.g., fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological S&I; existing access	$4,422
47539	New access, without placement of separate biliary drainage catheter	$4,422
47540	New access, with placement of separate biliary drainage catheter (eg, external or internal-external)	$4,422
47541	Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological S&I, new access	$1,201
+47542	Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (e.g., fluoroscopy), and all associated radiological S&I, each duct	$0.00

[3] Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Questions and Answers. https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/downloads/asc_qas_03072008.pdf

[4] Revised Payment System Policies for Services Furnished in ASCs Beginning CY 2008. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS1213393.html.

[5] Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Addenda AA, BB, and D1; http://www.cms.gov/HospitalOutpatientPPS, published by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule [CMS-1678-FC] on August 14, 2017, and published in the Federal Register on December 14, 2017.

[6] Healthcare Common Procedural Coding System (HCPCS) codes are developed by CMS and available in book form from several different publishers.

Hospital Outpatient Reimbursement

Outpatient facility claims also report CPT® and HCPCS[6] codes, which map to Ambulatory Payment Classifications (APCs), which assign a Medicare hospital outpatient payment rate for the service. Depending upon the services provided, hospitals may receive payment for more than one APC per patient encounter. If a claim contains services that result in an APC payment but also contains packaged services, no separate payment for the packaged services will be provided, as these are included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting. Therefore, it is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT® and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately or is packaged.

Common APCs for Endovascular Procedures

APC	Description	Status Indicator	2018 Relative Weight	2018 Medicare Base Payment Rate[7]
5341	Abdominal/Peritoneal/Biliary and Related Procedures (codes 47531, 47532)	Q2	32.5296	$2,558
5341	Abdominal/Peritoneal/Biliary and Related Procedures (code 47541)	J1	32.5296	$2,558
5361	Level 1 Laparoscopy and Related Services (codes 47538, 47539, 47540)	J1	57.0778	$4,488

Notes: Codes 47542, 74328, 74330, 74363 are not reimbursed through HOPPS; these codes are status "N", indicating they are packaged into the primary procedure.

OPPS payment status indicators (SIs) indicate whether a service represented by a HCPCS or CPT® code is payable under the OPPS or another payment system, and also whether particular OPPS policies apply to the code (eg, multiple procedure discounts or other payment reductions, full separate payment, or is a service packaged with another procedure). Relevant OPPS Status Indicators include:

J1 Comprehensive code: all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPPS SI = F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.

N Payment is packaged into payment for other services, including outliers; no separate APC payment.

Q2 T-Packaged Codes: (1) packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "T"; (2) in other circumstances, payment is made through a separate APC payment.

Modifiers

When submitting a particular service on a claim, it is sometimes necessary to report a modifier with the CPT® code. A modifier allows a way to indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. Some modifiers apply to either physician or hospital outpatient claims; some may only be relevant for one or the other. A complete list of modifiers is included in the HCPCS and CPT® coding books; the concept of modifiers does not apply to ICD-10-PCS procedure codes.

[7] Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Addenda A, B, and D1; http://www.cms.gov/HospitalOutpatientPPS [CMS-1677-F].

[8] CMS Fact Sheet: ICD-10-CM/PCS, The Next Generation of Coding, https://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10Overview.pdf and 2016 ICD-10-PCS Reference Manual, https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html

Hospital Inpatient Reimbursement

Selecting the Appropriate ICD-10-PCS Code

ICD-10-PCS, including the ICD-10-PCS Official Guidelines for Coding and Reporting, replaced ICD-9-CM procedure codes for dates of discharge for inpatients that occur on or after October 1, 2015. ICD-10-PCS is not related to ICD-10-CM, but was developed specifically to meet healthcare needs for a procedure code system.[8]

The ICD-10 updates for the Fiscal Year (FY) 2017 represents the first code update since the implementation of ICD-10-CM/PCS in the US. The following table lists some of the most commonly used code categories for biliary diagnostic and therapeutic procedures. Given the large number of individual procedure codes available for procedures in ICD-10-PCS, please refer to your coding reference book or coding software to look up the associated Body Part, Approach, Contrast, Device and/or Qualifier that best aligns to the procedure performed as identified below.

Common ICD-10-PCS Procedure Code Categories	
Procedure	**Description**
Imaging	
BF1– – – –	Imaging, hepatobiliary system and pancreas, fluoroscopy
BF2– – – –	Imaging, hepatobiliary system and pancreas, computed tomography
BF4– – – –	Imaging, hepatobiliary system and pancreas, ultrasound
Therapeutic Procedures	
0F7– – – –	Dilation, hepatobiliary system and pancreas
0F9– – – –	Drainage, hepatobiliary system and pancreas
0FC– – – –	Extirpation, hepatobiliary system and pancreas
0FH– – – –	Insertion, hepatobiliary system and pancreas
0FP– – – –	Removal, hepatobiliary system and pancreas
0FW– – – –	Revision, hepatobiliary system and pancreas
Other Supportive Therapies	
3E0– – – –	Injection or infusion (select 4th character for body part, 5th character for approach, and 6th or 7th characters for substance infused)
5A0C – 0Z	Extracorporeal assistance (biliary filtration)

If different methodologies are used in different sites, or if multiple root operations with different objectives are performed on the same body part, each procedure may have a separate code.

MS-DRGs

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), which bases payment on Medicare Severity Diagnosis-Related Groups (MS-DRGs). The MS-DRG payment system groups similar diagnoses into a single payment level, and reimburses the hospital according to the extent of resources typically required to treat patients with similar diagnoses undergoing similar treatments.

All services and supplies provided during the inpatient admission are bundled into a single MS-DRG reimbursement rate, regardless of the length of the inpatient stay, the intensity of treatments, or the number of procedures performed for the specific individual.

Common MS-DRGs for Endovascular Procedures[9]

MS-DRG	Description	2018 Mean Length of Stay	2018 Relative Weight	2018 Medicare Base Payment Rate[10]
435	Malignancy of hepatobiliary system or pancreas with MCC	6.4	1.6702	$10,486.45
436	Malignancy of hepatobiliary system or pancreas with CC	4.7	1.1355	$6,893.11
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	3.3	0.9093	$5,609.13

MCC = major complication or comorbidity
CC = complication or comorbidity

[9] Centers for Medicare and Medicaid Services, FY17 Final Notice Data, Table 5 - List of Medicare Severity Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay; http://www.cms.gov/AcuteInpatientPPS/ (under Acute Inpatient – Files for Download)
[10] The MS-DRG payment amounts indicated are estimates only based upon data elements derived from various CMS sources. MS-DRG national average payments were calculated with a base rate of $6,028.08 using the national adjusted operating standardized amounts and the capital standard federal payment rate as issued in the Medicare Inpatient Prospective Payment System Final Rule published in the Federal Register (Vol. 82, Issue 239) on 12/14/17; Tables 1A and 1D,Table 5, and assume that all hospitals are receiving the full 1.65% quality reporting and meaningful use updates. Actual payment may vary based on various hospital-specific factors not reflected in the source data.