2021 Coding & Reimbursement Guide for Hercules® 100 Transnasal Esophageal Balloon

Physician Coding and Reimbursement

This guide has been developed to assist with Medicare reporting and reimbursement of Transnasal Esophageal Dilation.

Currently (2021) a CPT code that accurately describes the Transnasal Esophageal Dilation procedure does not exist. Coding convention requires that you "select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code."[1]

The appropriate coding authorities suggest using the unlisted code 43499 "Unlisted procedure, esophagus," for the procedure, as provided in **Table A**.[2]

Table A – Transnasal Esophageal Dilation Codes CY 2021

CPT Code	Procedure Description	2021 Work RVUs	Total Non-Facility RVUs[4]	Total Facility RVUs[4]	Global Period (Days)
43499	Unlisted procedure, esophagus	N/A	N/A	N/A	0

Claim Submission

Submission of a claim with an unlisted code requires additional steps that will vary by payer.
For commercial payers, you may consider obtaining a prior authorization, as this will allow a physician to describe the planned procedure and medical necessity. This will help the payer understand the procedure being requested. Unlisted codes are not universally accepted by all insurance carriers. To avoid unnecessary claim denials, we encourage you to contact the payer for their coding recommendations prior to claim submission.

[1] American Medical Association. Instructions for use of the CPT code book. In: CPT 2021 Professional Edition. Chicago, IL: American Medical Association; 2020:xiii.

[2] AMA CPT® Knowledge Base- Article #6457 (2015, December 7),

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***Disclaimer**: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which may include, but are not limited to, the CPT, ICD-10 and MS-DRG coding systems; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, AHA, relevant medical societies, CMS, your local Medicare Administrative Contractor, and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.*

Physician Coding and Reimbursement (Cont.)

For Medicare, submitting an unlisted procedure claim will result in a Additional Documentation Request (ADR). The ADR letter requests supporting documentation, such as:

- Clinical notes
- Operative report
- A cover letter to the health plan/payer that contains the following information:
  1) Identification of comparable procedure(s) to assist the insurer in establishing a payment level, and an explanation of the procedure, the patient selection, the medical necessity, and clinical benefits.
  2) We also encourage you to include a copy of the Hercules 100 invoice that details the cost of the balloon.

Establishing a Value for an Unlisted Service

Common questions physicians ask when starting to perform a new service are: "How much do I charge for the procedure?" and "How much should I expect to be reimbursed for the procedure?" Obviously, setting fees is a business decision that must be addressed by the physician and/or designated personnel. However, Medicare law requires that payments under the Medicare fee schedule be based on national, uniform relative value units (RVUs) determined by the resources used in furnishing a service.[2] Centers for Medicare and Medicaid Services' (CMS) reasoning behind the law is that the relative value of the work in a physician's service exists only in comparison with the physician's work in another service; therefore, CMS established a set of reference services. The criteria for the reference services were that they must be commonly performed with established work RVUs and be well understood outside of their own specialty.[3] The work RVU assigned to the reference services represents benchmarks for comparison with the work represented by other codes.

To help the reader make a value determination, a sample of reference service CPT codes are provided in **Table B**. While specific samples are provided in **Table B**, any CPT code may be used as a reference code. When establishing the value for Transnasal Esophageal Dilation, consider the amount of time, skill, risk, and intensity of work. Referencing the information in the table below may aid your decision making and provide a defensible rationale for your value determination.

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Table B – Sample Reference Service CPT Codes CY 2021

CPT Code	Procedure Description	2021 Work RVUs[4]	Total Non-Facility RVUs[4]	Total Facility RVUs[4]	Global Period (Days)
43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)	2.00	30.22	3.44	0
43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.67	34.45	4.47	0

[2]Section 1848 of the Social Security Act, "Payment for Physicians' Services."

[3] Fed Regist. 1999;64(211):59428.

[4]2021 Medicare Physician Fee Schedule.

Coding Tip: As of January 1, 2017, moderate sedation is no longer bundled into gastrointestinal endoscopy procedural codes. Separate billing for moderate sedation must be billed with codes 99151-99157 and G0500.

Things to Remember

- Coding convention requires that you "select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code."
- Include all supporting documentation that provides a detailed description of the procedure.
- Choose a comparable procedure code that reflects a similar amount of time, skill, risk, and intensity of work as the unlisted procedure performed.
- Contact payers for their coding recommendations prior to claim submission.

If you have any questions, please contact our reimbursement team at
800.468.1379 or
by e-mail at:
reimbursement@cookmedical.com

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