

Instinct Plus™ Endoscopic Clipping Device

2026 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and payment for medical procedures and devices can be complicated and confusing. This guide was developed to assist with Medicare reporting and reimbursement when placing endoscopic clips. If you have any questions, please contact our reimbursement team at 833.585.2688 or by e-mail at Reimbursement@CookMedical.com.

Coverage

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (<http://www.cms.hhs.gov/mcd/search.asp?>) and encouraged to contact their local carrier medical directors (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

Coding

CPT Coding

CPT coding convention requires that you "[S]elect the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the services provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code."¹ Currently, there are no specific codes to report endoscopic marking using endoscopic clips.

The following codes may be reported for endoscopic control of bleeding. Control of bleeding should not be reported when bleeding occurs as the result of an endoscopic procedure.¹

43227	Esophagoscopy, flexible, transoral; with control of bleeding, any method
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method
44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)
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)
44391	Colonoscopy through stoma; with control of bleeding, any method
45334	Sigmoidoscopy, flexible; with control of bleeding, any method
45382	Colonoscopy, flexible; with control of bleeding, any method

HCPCS Coding

C9901 may be used by hospitals to report defect closure procedures performed in the outpatient setting. However, endoscopic defect closure cannot be billed if it is secondary to another procedure as it would be considered inherent in the primary procedure. If endoscopic defect closure is performed at a separate session, then it would be separately billable. Private payers may or may not accept this code for claims processing. Please contact your local payers for guidance.

C9901

Endoscopic defect closure within the entire gastrointestinal tract, including upper endoscopy (including diagnostic, if performed) or colonoscopy (including diagnostic, if performed), with all system and tissue anchoring components

Payment

2026 Medicare Reimbursement for Endoscopic Clipping

CPT Code	Description	Ambulatory Surgery Center		Outpatient Hospital		Physician Services	
		Facility Payment (National Medicare Avg) ²	APC	Facility Payment (National Medicare Avg) ³		Fee When Procedure Is Performed In Hospital/ASC (National Medicare Avg) ⁴	Fee When Procedure Is Performed In Office (National Medicare Avg) ⁴
43227	Esophagoscopy, flexible, transoral; with control of bleeding, any method	\$894.33	5302	\$1,960.47		\$147.70	\$659.27
43255	Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method	\$894.33	5302	\$1,960.47		\$177.91	\$692.83
44366	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	\$894.33	5302	\$1,960.47		\$211.48	NA*
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)	\$894.33	5302	\$1,960.47		\$336.68	NA*
44391	Colonoscopy through stoma; with control of bleeding, any method	\$656.75	5312	\$1,222.56		\$204.09	\$705.59

CPT Code	Description	Ambulatory Surgery Center		Outpatient Hospital		Physician Services	
		Facility Payment (National Medicare Avg) ²	APC	Facility Payment (National Medicare Avg) ³		Fee When Procedure Is Performed In Hospital/ASC (National Medicare Avg) ⁴	Fee When Procedure Is Performed In Office (National Medicare Avg) ⁴
45334	Sigmoidoscopy, flexible; with control of bleeding, any method	\$656.75	5312	\$1,222.56		\$106.41	\$547.15
45382	Colonoscopy, flexible; with control of bleeding, any method	\$656.75	5312	\$1,222.56		\$227.92	\$734.12
C9901	Endoscopic defect closure within the entire gastrointestinal tract, including upper endoscopy (including diagnostic, if performed) or colonoscopy (including diagnostic, if performed), with all system and tissue anchoring components	\$6,759.42	5362	\$10,860.07	Code cannot be reported on physician claims	Code cannot be reported on physician claims	

¹ American Medical Association. CPT 2026 Professional Edition. Chicago, IL: American Medical Association.

² 2026 Medicare Ambulatory Surgery Center Fee Schedule

³ 2026 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule

⁴ 2026 Medicare Physician Fee Schedule. The rates shown in this guide reflect the CY 2026 qualifying APM conversion factor of \$33.57. For reference, the CY 2026 nonqualifying APM conversion factor is \$33.40.

*Medicare has not developed a rate for the in-office setting because these procedures are typically performed in a hospital setting. Physicians should contact the Medicare contractor to determine if the service can be performed in-office. If the contractor determines the service or procedure may be performed in-office, the physician will receive Medicare's physician fee schedule amount for procedures performed in the hospital/ASC.

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2026 physician fees for your local area can be found at the following CMS link:

<https://www.cms.gov/medicare/physician-fee-schedule/search>



Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources that may include, but are not limited to, the CPT coding system; 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 you are making coding decisions, we encourage you to seek input from the AMA, 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.