aScope™ Duodeno:
2024 Coding and Payment Reference Guide

Effective January 1, 2024

Ambu

About the aScope Duodeno

The Ambu® aScope™ Duodeno is a sterile single-use duodenoscope that seamlessly integrates into existing hospital systems and offers an intuitive, lightweight design with similar functionality to reusable duodenoscopes. The aScope Duodeno is part of a system that includes a reusable processor, the Ambu aBox™ Duodeno. Duodenoscopes are used for visual examination of the duodenum and play a key role in diagnosis and treatment of conditions like gallstones, pancreatitis, and tumors or cancer in the bile duct and pancreas.

HOSPITAL OUTPATIENT DEPARTMENT CODING AND PAYMENT

The following sections provide an overview of potential billing and coding and Medicare national payment rates when aScope Duodeno is used in the hospital outpatient department (HOPD) setting.

Please note: Per CMS Transmittal MM13216 Transitional Pass Through (TPT) Status for HCPCS C1748: Endoscope, single-use (i.e. disposable), upper GI, imaging/illumination device (insertable) has expired as of 07/01/2023. Payment for the aScope Duodeno is now packaged with the primary procedure. The supply may still be reported to CMS using C1748.

CPT Codes and 2024 Medicare National Average Payment for Radiological Supervision and Interpretation

CPT codes for fluoroscopic imaging of the ductal systems (74328, 74329, 74330) may be reported, if applicable. The service must be documented in the patient record, including supervision, interpretation, reporting and saving the images to the permanent record. If the surgeon performing the ERCP performs the imaging of the ductal system, Modifier -26 should be included for the professional component. Note that this code is a physician-only code that is not reported by the facility.

CPT[1] Code	Descriptor	Physician Service Payment[2]		Facility Payment[3]	
		Total RVUs (in Facility)	Physician Payment (in Facility)	HOPD Payment	APC
74328	Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation	0.68	$22.64	n/a	n/a
74329	Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation	0.69	$22.97	n/a	n/a
74330	Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation	n/a	$26.63	n/a	n/a

CPT Codes and 2024 Medicare National Payment Rates for ERCP Procedures

CPT Code	Descriptor	Physician Service Payment[2]		Facility Payment[3]	
		Total RVUs (in Facility)	Physician Payment (in Facility)	HOPD Payment	APC
43260	Endoscopic retrograde cholangiopancreatography (ERCP); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	9.5	$316.23	$3,648.96	5303
43261	Endoscopic retrograde cholangiopancreatography (ERCP); with biopsy, single or multiple	9.97	$331.88	$3,648.96	5303
43262	Endoscopic retrograde cholangiopancreatography (ERCP); with sphincterotomy/papillotomy	10.5	$349.52	$3,648.96	5303
43263	Endoscopic retrograde cholangiopancreatography (ERCP); with pressure measurement of sphincter of Oddi	10.52	$350.18	$1,812.99	5303
43264	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of calculi/debris from biliary/pancreatic duct(s)	10.71	$356.51	$3,648.96	5303
43265	Endoscopic retrograde cholangiopancreatography (ERCP); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)	12.74	$424.08	$5,430.19	5331
43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	13.61	$453.04	$5,430.19	5331
43275	Endoscopic retrograde cholangiopancreatography (ERCP); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	11.07	$368.49	$1,812.99	5303
43276	Endoscopic retrograde cholangiopancreatography (ERCP); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	14.17	$471.68	$5,430.19	5331
43277	Endoscopic retrograde cholangiopancreatography (ERCP); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct	11.13	$370.49	$3,648.96	5303
43278	Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed	12.74	$424.08	$3,648.96	5303

HOSPITAL INPATIENT DEPARTMENT CODING AND PAYMENT

The following sections provide an overview of potential billing and coding and Medicare national payment rates when aScope Duodeno is used in the hospital inpatient setting.

2023 Medicare MS-DRG Payments

Medicare Severity Diagnosis Related Groups (MS-DRGs) assignment will vary based on the patient's diagnoses and procedure(s) performed during the patient encounter. Below are the most common MS-DRGs reported for procedures that may involve the aScope Duodeno; however, others may apply.

MS-DRG	Descriptor	Medicare National Average Base Payment Rate[4]
435	Malignancy of hepatobiliary system or pancreas with MCC	$11,252
436	Malignancy of hepatobiliary system or pancreas with CC	$7,038
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,314
438	Disorders of pancreas except malignancy with MCC	$10,670
439	Disorders of pancreas except malignancy with CC	$5,468
440	Disorders of pancreas except malignancy without CC/MCC	$3,936
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC	$11,689
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC	$6,084
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis without CC/MCC	$4,570
444	Disorders of the biliary tract with MCC	$10,442
445	Disorders of the biliary tract with CC	$6,949
446	Disorders of the biliary tract without CC/MCC	$5,175

MCC: Major Complication or Comorbidity
CC: Complication or Comorbidity

Revenue Codes

Revenue codes are used by hospitals to report services and supplies to specific cost centers.
The following are potential revenue codes that may be used when billing for the aScope Duodeno.

Revenue Code	Descriptor
272	Sterile supplies
278[5]	Other implants

REFERENCES

1. Current Procedural Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.
2. 2024 CMS PFS Final Rule: https://www.federalregister.gov/d/2023-24184.
3. 2024 CMS OPPS Final Rule, Addendum A and B (available on CMS website), (Jan. 2024).
4. 2024 CMS IPPS Final Rule, Tables 1B and 5 (available on CMS website). DRG payment rates rounded to nearest dollar and assumes the hospital received the full update. Payment will vary based on geographic location and other factors.
5. Items that are insertable may be billed with revenue code 0278 per the National Uniform Billing Committee (NUBC)'s Updated Guidance on Other Implant Revenue Code (0278) effective Jul. 1, 2020 available at: https://www.nubc.org/updated-guidance-other-implant-revenue-code-0278-effective-july-1-2020

INDICATIONS FOR USE

The aScope Duodeno is designed to be used with the aBox Duodeno, endoscopic accessories (e.g. biopsy forceps) and other ancillary equipment (e.g. video monitor) for endoscopy and endoscopic surgery within the duodenum.

The aBox Duodeno is designed to be used with the aScope Duodeno, endoscopic accessories (e.g. biopsy forceps) and other ancillary equipment (e.g. medical grade video monitor) for endoscopy and endoscopic surgery within the duodenum.

DISCLAIMER

The reimbursement information provided in this Guide was obtained from third-party sources and information that is publicly available on the internet. The reported Medicare national average payments are subject to change and may vary based on geographic location and other individual factors. Information in this Guide is not legal advice, nor is it advice about how to code or complete claims for payment. It is the provider's responsibility to report the appropriate codes based on the procedures furnished to a specific patient and the patient's documented medical condition. Providers are also responsible for submitting claims for these services consistent with the specific payer billing requirements.

Payer billing, coding, and coverage requirements vary from payer to payer and are updated and change over time. Ambu encourages providers to verify current billing, coding and coverage policies and requirements with the specific payer if the provider has questions. Providers may also contact the American Gastroenterology Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE) and/or the American Medical Association (AMA).

Ambu does not promote the use of its products outside of the FDA cleared indications for use and labeling.

For more information, please contact (800) 262-8462, select option 7 or email **us-reimbursement@ambu.com**

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