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2023 Coding & Payment Quick Reference

Select Gastroenterology (GI) Dilation Procedures

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

The following codes are thought to be relevant to GI Dilation procedures and are referenced throughout this guide.

All rates shown are 2023 Medicare national averages; actual rates will vary geographically and/or by the individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

						2023 Medicare National Average Payment				
			RVUs			Physician[‡, 2]		Facility[3]		
APC	**CPT® Code[1]**	**Code Description**	**Work**	**Total Office**	**Total Facility**	**In-Office**	**In-Facility**	**Hospital Outpatient**	**ASC**	**Comments**
Balloon										
5303[†]	43195	Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)	3.07	NA	5.51	NA	$187	$3,261	$1,501	The endoscope remains in place as balloon dilation occurs[4]
5302[†]	43214	Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	3.40	NA	5.73	NA	$194	$1,742	$752	Typically used for achalasia[5]
5302[†]	43220	Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)	2.00	27.28	3.47	$924	$118	$1,742	$752	The endoscope remains in place as balloon dilation occurs[4]
5302[†]	43233	Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)	4.07	NA	6.71	NA	$227	$1,742	$752	Typically used for achalasia[5]
5302[†]	43249	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)	2.67	32.70	4.51	$1,108	$153	$1,742	$752	Does not require a guidewire for balloon dilation
5302[†]	44381	Ileoscopy, through stoma; with transendoscopic balloon dilation	1.38	29.82	2.50	$1,011	$85	$1,742	$752	Does not require a guidewire for balloon dilation
5312[†]	44405	Colonoscopy through stoma; with transendoscopic balloon dilation	3.23	16.73	5.37	$567	$182	$1,083	$785	Does not require a guidewire for balloon dilation
5312	45340	Sigmoidoscopy, flexible; with transendoscopic balloon dilation	1.25	13.82	2.31	$468	$78	$1,083	$564	Does not require a guidewire for balloon dilation
5312	45386	Colonoscopy, flexible; with transendoscopic balloon dilation	3.77	18.39	6.21	$623	$210	$1,083	$564	Does not require a guidewire for balloon dilation
Balloon or Rigid										
5303[†]	43196	Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire	3.31	NA	5.81	NA	$197	$3,261	$1,501	Guidewire must be used with a balloon dilator
5302[†]	43213	Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)	4.63	37.46	7.66	$1,269	$260	$1,742	$752	Retrograde dilation
5302[†]	43226	Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire	2.24	11.65	3.84	$395	$130	$1,742	$752	Guidewire must be used with a balloon dilator
5302[†]	43245	Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (e.g., balloon, bougie)	3.08	17.94	5.16	$608	$175	$1,742	$752	Utilized to report dilation of gastric outlet, native or post-op (e.g., gastro-jejunal bypass)[5]
5301	43248	Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire	2.91	12.43	4.87	$422	$165	$826	$430	Guidewire must be used with a balloon dilator

See important notes on the uses and limitations of this information on page 2.

5312	45303	Proctosigmoidoscopy, rigid; with dilation (e.g., balloon, guide wire, bougie)	1.40	28.97	2.53	$982	$86	$1,083	$564

C-Code Information

For all C-Code information, please reference the C-Code Finder.

Medicare Hospital Inpatient Payment

Inpatient payment information is not shown because dilation procedures will rarely, if ever, be the primary reason for hospital admission.

Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.

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† Comprehensive APCs (C-APCs): CMS implemented their C-APC policy with the goal of identifying certain high-cost device-related outpatient procedures (formerly "device intensive" APCs). CMS identifies these high-cost, device-related services as the primary service on a claim. All other services reported on the same date will be considered "adjunctive, supportive, related or dependent services" provided to support the delivery of the primary service and will be unconditionally packaged into the OPPS C-APC payment of the primary service. Certain exceptions are defined under CMS's C-APC "complexity adjustment" policy and can be found in the OPPS Addenda files (Addendum J).

± Device Intensive ASC Payment Indicator (Addendum AA)

‡ The 2023 National Average Medicare physician payment rates have been calculated using a 2023 conversion factor of $33.8872. Rates subject to change.

NA "NA" indicates that there is no in-office differential for these codes.

1. Current Procedural Rate (CPT) 2022 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
2. Centers for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2023 release CMS-1770-F | CMS
3. Center for Medicare and Medicaid Services. CMS Hospital Outpatient and Ambulatory Surgery Center Payment Schedules – January 2023 release, CMS-1772-FC | CMS.
4. General Surgery/Gastroenterology 2008 Coding Companion. Ingenix. p. 245-9
5. ASGE 2014 CPT Coding Updates

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