

# EsophyX<sup>®</sup> Z+

## ESOPHYX Z+ 2026 MERIT MEDICAL REIMBURSEMENT GUIDE

This document provides coding and reimbursement information for physicians and health care facilities. It includes commonly used codes to reflect procedures involving Merit Medical Systems, Inc EsophyX Z+; it is not an all-inclusive list. All payment rates shown are unadjusted 2026 Medicare national averages; actual payments will vary by geographic and individual facility adjustment factors. The provider has the sole responsibility to determine medical necessity, accurately document patient care and determine appropriate codes and charges for medically necessary care provided. The information in this guide is intended to support the use of Merit's products consistent with their FDA-approved/cleared indications.

Please see the end of document for disclaimers regarding the intent of this guide, provider responsibilities, and promotional restrictions.

### PHYSICIAN, HOSPITAL OUTPATIENT AND ASC CODING AND PAYMENT

Medicare and most other insurers commonly reimburse physicians based on fee schedules tied to Current Procedural Terminology (CPT<sup>®</sup>) codes used to report procedures and services. Each CPT is assigned Relative Value Units (RVUs). Payment reductions may apply when multiple procedures are reported. Physician payment for procedures performed in an outpatient or inpatient hospital or Ambulatory Surgical Center (ASC) setting is described as a facility payment; while payment for procedures performed in the physician office is described as a non-facility payment.

Medicare Hospital outpatient reimbursement is based on Ambulatory Payment Classification (APC) groups. APC assignment is made on the basis of CPT codes. Hospital outpatient and ASC reimbursement is subject to various multiple procedure packaging rules, including Comprehensive APCs (C-APCs), under which a single payment is made for all procedures and supplies provided.

The CPT codes commonly used to report use of EsophyX Z+ for OPPS, ASC, and physician payment are provided below.

The payment rates provided represent the 2026 unadjusted Medicare national average.

CPT	Descriptor	OPPS			ASC	Physician			
		APC	SI	Payment	Payment	Non-Facility		Facility	
						wRVUs	Payment	wRVUs	Payment

#### Stand-alone TIF procedure

43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	5362	J1	\$10,860	\$7,481	N/A	N/A	7.56	\$379
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CPT	Descriptor	OPPS			ASC	Physician			
		APC	SI	Payment	Payment	Non-Facility		Facility	
						wRVUs	Payment	wRVUs	Payment

**TIF performed in same encounter as laparoscopic hernia repair**

43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	5362	J1	\$10,860	\$7,481	N/A	N/A	7.56	\$379
43289	Unlisted laparoscopy procedure, esophagus	When 43289 is performed with 43210- APC is bundled to APC 5362			Unlisted CPT codes are not covered in the ASC setting under CMS.	Report unlisted procedure codes for physician services in accordance with individual third-party payer policies, including relevant medical documentation and comparable procedural references to assist in valuation.			

Merit Medical System offers a TIF Patient Access Support Program. See details on page 3.

AHA Coding Clinic for HCPCS - 2021 Issue 3 identifies CPT codes 43210 and 43289 for the transoral endoscopic fundoplication performed with the laparoscopic hernia repair in the same encounter. Hospital reimbursement for this code combination aligns to the APC listed. Unlisted codes, including 43289, do not have assigned relative value units (RVUs), therefore do not have assigned physician payment rates. Physician claims submitted with unlisted CPT codes should include supporting documentation including operative notes, clinical rationale, device description, and comparable procedural references when applicable. It may be necessary to provide comparison (or proxy) codes for the unlisted services.

CY 2026 Medicare OPPS & ASC Payment System Final Rule (CMS-1834-FC); Addendum B and ASC Addenda.

CY 2026 Physician Fee Schedule Final Rule (CMS-1832-F); Addendum B. Work RVUs provided. National average physician payment reflects total RVUs calculated with the Non-Qualifying QP CF of \$33,4009.

J1 = Comprehensive APC (C-APC); Paid under OPPS; all covered Part B services on the claim are packaged with the primary service for the claim, except services with OPPS SI=F, G, H, L and U.

**LEVEL II HCPCS CODES**

HCPCS	Descriptor
C1889	Implantable/insertable device, not otherwise classified

**HOSPITAL INPATIENT CODING AND REIMBURSEMENT**

**MEDICARE SEVERITY DIAGNOSIS RELATED GROUPS (MS-DRGS)**

Medicare reimbursement for inpatient hospital services is based on Medicare Severity Diagnosis Related Groups (MS-DRGs). One MS-DRG is assigned per hospital admission, determined by patient diagnoses and procedures reported; one payment is made for all procedures and supplies associated with an individual hospital stay.

Potential MS-DRG assignments for admissions involving the EsophyX Z+ device, and Medicare 2026 national average unadjusted rates are shown below.

MS-DRG	Descriptor	Payment
326	Stomach, Esophageal and Duodenal Procedures with MCC	\$36,292
327	Stomach, Esophageal and Duodenal Procedures with CC	\$17,786
328	Stomach, Esophageal and Duodenal Procedures with CC/MCC	\$11,660

CY 2026 Medicare Inpatient Final Rule (CMS-1833-F). Rates shown assume the hospital submitted quality data and is a user of EHR. The hospital's base payment rate will change if the hospital does not meet either or both of these measures. Calculations were based on data provided in FY 2026 IPPS Final Rule CN (Tables 1A, 1D, and 5CN). Secondary diagnoses included on the CMS lists for Major Complication or Comorbidity (MCC) or Complication or Comorbidity (CC) may impact MS-DRG assignment. Please note that all Medicare rates displayed in this table reflect the national unadjusted amounts inclusive of beneficiary cost sharing and do not reflect any additional payment adjustments.

## ICD-10-PCS PROCEDURE CODES FOR INPATIENT HOSPITAL BILLING

ICD-10-PCS codes are used by hospitals for reporting inpatient services. The following list provides common codes associated with procedures involving the EsophyX Z+ device; it is not all-inclusive.

ICD-10-PCS	Descriptor
0DV48DZ	Restriction of Esophagogastric Junction with Intraluminal Device, Via Natural or Artificial Opening Endoscopic

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For questions related to enrollment into the TIF Access Program please contact:  
833-274-5070 or [TAPsupportprogram@JDLaccess.com](mailto:TAPsupportprogram@JDLaccess.com)

For general reimbursement questions please contact:  
[TAPhotline@JDLaccess.com](mailto:TAPhotline@JDLaccess.com)

Before using, refer to Instructions for Use for indications, contraindications, warnings, precautions, and directions for use.



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