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2024 Coding & Payment Quick Reference

Endoluminal Surgery (ELS)

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 ELS procedures and are referenced throughout this guide.

All rates shown are 2024 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Endoscopic Mucosal Resection (EMR)

Medicare Physician, Hospital Outpatient, and ASC Payments

			RVUs			2024 Medicare National Average Payment			
						Physician‡, [2]		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
EMR									
5302†	43211	Esophagoscopy, flexible, transoral; with endoscopic mucosal resection	4.20	6.92	NA	$227	NA	$1,813	$832
5302†	43254	Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection	4.87	7.95	NA	$260	NA	$1,813	$832
5312	44403	Colonoscopy through stoma; with endoscopic mucosal resection	5.50	8.96	NA	$293	NA	$1,124	$612
5313†	45349	Sigmoidoscopy, flexible; with endoscopic mucosal resection	3.52	5.84	NA	$191	NA	$2,675	$1,349
5313†	45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.04	9.79	NA	$321	NA	$2,675	$1,349

Endoscopic Submucosal Dissection (ESD)

Medicare Hospital Outpatient Payment

The Centers for Medicare & Medicaid Services (CMS) established a new HCPCS Code describing the Endoscopic Submucosal Dissection (ESD) procedure during an endoscopy or colonoscopy. HCPCS Code C9779 may be used by hospitals to report ESD procedures performed in the outpatient setting.

APC	HCPCS Code	Description	2024 Medicare National Average Payment[3]
5303†	C9779	Endoscopic submucosal dissection (ESD), including endoscopy or colonoscopy, mucosal closure, when performed	$3,649

ESD Medicare Physician Payments

Currently, there is no unique Current Procedural Terminology (CPT) codes for ESD. In the absence of a unique ESD code, physicians may bill an unlisted procedure code. Physicians should submit a cover letter with the claim that explains the nature of the procedure, equipment required, estimated practice cost, and a comparison of physician work (time, intensity, risk) with other comparable services for which the payer has an established value.

			RVUs			2024 Medicare National Average Payment	
						Physician‡, [2]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office
ESD							
5301	43499	Unlisted procedure, esophagus	NA	NA	NA	NA	NA
5301	43999	Unlisted procedure, stomach	NA	NA	NA	NA	NA
5301	44799	Unlisted procedure, small intestine	NA	NA	NA	NA	NA
5311	45399	Unlisted procedure, colon	NA	NA	NA	NA	NA
5311	45999	Unlisted procedure, rectum	NA	NA	NA	NA	NA

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

Peroral Endoscopic Myotomy (POEM)

Medicare Physician and Hospital Outpatient Payments

The American Medical Association (AMA) established a new CPT Code describing the Peroral Endoscopic Myotomy (POEM) procedure. CPT Code 43497 may be used to report POEM procedures.

			RVUs			2024 Medicare National Average Payment			
						Physician‡, 2		Facility[3]	
APC	CPT® Code[1]	Code Description	Work	Total Facility	Total Office	In-Facility	In-Office	Hospital Outpatient	ASC
POEM									
5331†	43497	Lower esophageal myotomy, transoral (i.e., Peroral endoscopic myotomy [POEM])	13.29	23.49	NA	$769	NA	$5,430	N/A

Endoscopic Closure

Currently, there is no unique Current Procedural Terminology (CPT) codes for Endoscopic Closure. In the absence of a unique code, providers may bill an unlisted procedure code. For closure of a perforation, fistula or leaks, it would be an unlisted procedure code for the area in which closure is performed. Average payments for unlisted procedure codes reflect payment for all unlisted procedures.

Disclaimer

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).

‡ The 2024 National Average Medicare physician payment rates have been calculated using a 2024 conversion factor of $32.7442. Rates subject to change.

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

N/A Medicare has not developed a rate for the ASC setting as the procedure is typically performed in the hospital setting.

1. Current Procedural Rate (CPT) 2023 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 2024 release RVU24A | CMS.
3. Center for Medicare and Medicaid Services. CMS Hospital Outpatient and Ambulatory Surgery Center Payment Schedules – January 2024 release, Addendum B | CMS.

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