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2020 Coding & Payment Quick Reference

Select Endoscopic Ultrasound-Guided 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 Endoscopic Ultrasound-Guided procedures and are referenced throughout this guide.

All rates shown are 2020 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Medicare Physician, Hospital Outpatient, and ASC Payments

		RVUs			2020 Medicare National Average Payment			
					Physician[‡,2]	Facility[3]		
CPT® Code[1]	Code Description	Work	Total Office	Total Facility	In-Office	In-Facility	Hospital Outpatient	ASC
Upper Gastrointestinal Procedures								
43232	Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)	3.59	NA	5.75	NA	$208	$1,557[†]	$663
43238	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)	4.16	NA	6.70	NA	$242	$1,557[†]	$663
43242	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	4.73	NA	7.58	NA	$274	$1,557[†]	$663
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	2.96	5.92	4.88	$334	$176	$2,999[†]	$1,306
43253	Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	4.73	NA	7.60	NA	$274	$1,557[†]	$663
Lower Gastrointestinal Procedures								
44407	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	4.96	NA	7.95	NA	$287	$1,004	$507
45342	Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)	2.98	NA	4.89	NA	$176	$1,004	$507
45392	Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	5.50	NA	8.78	NA	$317	$1,004	$507

C-Code Information

For all C-Code information, please reference the C-code Finder: http://www.bostonscientific.com/reimbursement

Medicare Hospital Inpatient Payment

Inpatient payment information not shown because the endoscopic ultrasound-guided fine needle aspiration procedure will rarely, if ever, be the primary reason for a hospital admission.

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

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.

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered. It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label. Information included herein is current as of November 2019 but is subject to change without notice. Rates for services are effective January 1, 2020.

† Comprehensive APCs (C-APCs): In 2014, CMS implemented their C-APC policy with the goal of identifying certain high-cost device-related outpatient procedures (formerly "device intensive" APCs). CMS has fully implemented this policy and has identified 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 with minor exceptions.

‡ The 2020 National Average Medicare physician payment rates have been calculated using a 2020 conversion factor of $36.0896. Rates subject to change.

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

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2 Center for Medicare and Medicaid Services. CMS Physician Fee Schedule - November 2019 release, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.html

3 January 2020 Federal Register CMS-1717-CN.

SEQUESTRATION DISCLAIMER: Rates referenced in these guides do not reflect Sequestration, automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2020.

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