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GI

Endoscopic Resection & Tattooing

2025 Reimbursement Guide

GASTROENTEROLOGY

Submucosal Injection for Endoscopic Resection and Tattooing

Introduction

This guide provides general coding and payment information to physicians and facilities submitting claims for procedures including the Spot® Ex Endoscopic Tattoo and EverLift® Submucosal Lifting Agent.

This guide is not exhaustive of all coding options for procedures involving Spot Ex and EverLift. These coding suggestions and coverage guidelines do not replace seeking coding advice from the payer and/or your coding staff. The ultimate responsibility for correct coding lies with the provider of services. Please contact your local payer for interpretation of the appropriate codes to use for specific procedures. Laborie makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other third-party payers as to the correct form of billing or the amount that will be paid to providers of service.

CODING

Coding is the “language of reimbursement" and is how providers and payers adjudicate claims for medical services.

For the use of Spot Ex and EverLift, there are various CPT® codes that may be applicable depending on the anatomic location where it is being utilized, and the method of delivery. The following CPT procedure codes describe submucosal injections, which include Spot Ex and EverLift.

When utilizing CPT codes, it may be appropriate to include modifiers based on the patient condition and/or procedure. Providers should ensure the proper use of modifiers to ensure correct claims submission.

There are no separate HCPCS Level II codes associated with Spot Ex or EverLift.

COVERAGE

Coverage is the health plan’s authority to allow a service to be performed for which they will provide payment. Coverage describes under what circumstances a procedure or service is (or is not) covered and can exclude certain items or services. Health plans generally cover procedures that are considered reasonable and medically necessary.

Although Medicare, Medicaid, and most private health plans typically provide coverage for these services when performed for the appropriate indications, health plans may have specific utilization management guidelines regarding frequency, patient selection and prior authorization requirements. As policies change over time, it is a best practice to contact the patient’s health plan to understand their coverage guidelines for a particular item or service in advance of performing the procedure.

Endoscopic Resection and Tissue Marking National Payment

Marking for Surgical Localization and Clinical Surveillance

	Colonoscopy with Polyp Removal, Snare (CPT 45385)		Submucosal Injection (CPT 45381)
Physician (Facility)	**$242.28** Work RVU: 4.57	+	**$190.20** (Total $432.38) Work RVU: 3.56 RVU: 5.98
ASC	**$632.96**	+	**$632.96** (Total $1,265.92)
Hospital Outpatient	**$1,179.08**	+	**$1,179.08** (Total $2,358.16)

Complex Polypectomy and Endoscopic Mucosal Resection (EMR)

	Colonoscopy with Polyp Removal, Snare (CPT 45385)		Submucosal Injection (CPT 45381)	EMR (CPT 45390)
Physician (Facility)	**$242.28** Work RVU: 4.57	+	**$190.20** (Total $432.48) Work RVU: 3.56 RVU: 5.88	**$316.67** Work RVU: 6.04
ASC	**$632.96**	+	**$632.96** (Total $1,265.92)	**$1,397.97**
Hospital Outpatient	**$1,179.08**	+	**$1,179.08** (Total $2,358.16)	**$2,742.39**

Note: Individual provider payment will vary
Source: CMS-1770-F, CMS-1772-FC Addendum B, and CMS-1772-FC Addendum AA.

Payment

Listed below are 2025 Medicare national average payment rates for physicians, hospital outpatient, and ambulatory surgery centers (ASCs) for select procedures applicable to utilizing Spot Ex and EverLift:

Medicare Physician, Hospital Outpatient, and ASC Payments

CPT	CODE DESCRIPTION	PHYSICIAN: RVUs[1]			PHYSICIAN: PAYMENT[1]*		FACILITY		
		WORK	TOTAL OFFICE	TOTAL FACILITY	OFFICE	FACILITY	HOSPITAL OUTPATIENT[2]		ASC[3]
							APC	PAYMENT	
43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance	2.79	NA	5.09	NA	$164.64	5302	$1,896.99	$864.15
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	1.72	7.79	3.08	$251.98	$99.63	5302	$1,896.99	$864.15
43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance	2.39	12.02	4.10	$388.80	$132.62	5301	$937.56	$503.39
44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance	3.02	12.60	5.07	$407.57	$164.00	5312	$1,179.08	$632.96
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	1.04	8.71	1.99	$281.74	$64.37	5311	$871.71	$489.47
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	3.56	13.26	5.88	$428.91	$190.20	5312	$1,179.08	$632.96

1. CMS-1770-F, Addendum B multiplied by 2025 conversion factor ($32.35) 2. CMS-1772-FC, Addendum B, 3. CMS-1772-FC, Addendum AA
Note: Payment rates listed represent 2025 Medicare national payment amounts, individual provider payment will vary

Unlisted Procedures CPT Codes

CPT	CODE DESCRIPTION	PHYSICIAN: PAYMENT[1]		FACILITY		
		OFFICE	FACILITY	HOSPITAL OUTPATIENT[2]		ASC[3]
				APC	PAYMENT	
43999	Unlisted procedure, stomach	NA	NA	5301	$937.56	NA
44799	Unlisted procedure, small intestine	NA	NA	5301	$937.56	NA
45999	Unlisted procedure, rectum	NA	NA	5311	$871.71	NA

1. CMS-1770-F, Addendum B multiplied by 2025 conversion factor ($32.35), 2. CMS-1772-FC, Addendum B, 3. CMS-1772-FC, Addendum AA
Note: Payment rates listed represent 2025 Medicare national payment amounts, individual provider payment will vary

Hospital Outpatient

APC	APC DESCRIPTION	STATUS INDICATOR	MEDICARE PAYMENT[1]
5301	Level 1 Upper GI Procedures	T	$938
5302	Level 2 Upper GI Procedures	J1	$1,897
5311	Level 1 Lower GI Procedures	T	$912
5312	Level 2 Lower GI Procedures	T	$1,179

1. CMS-1772-FC, Addendum B
Note: Status Indicator J1- covered services on claim are packaged with primary "J1" service for the claim; T-Multiple surgical reduction applies

Endoscopy Procedure Payment

EverLift and Spot Ex are typically used in colonoscopy procedures that include the resection of tumor(s), polyp(s), or other lesion(s) by snare or endoscopic mucosal resection (EMR). These procedure codes are used for payment in conjunction with the procedure codes for any submucosal injection.

CPT	CODE DESCRIPTION	RVUS[1]			PHYSICIAN[1]*		FACILITY		
		WORK	TOTAL OFFICE	TOTAL FACILITY	OFFICE	FACILITY	HOSPITALOUTPATIENT[2]		ASC[3]
							APC	PAYMENT	
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.57	13.60	7.49	$439.91	$242.28	5312	$1,179.08	$632.96
45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.04	NA	9.79	NA	$316.67	5313	$2,742.39	$1,397.97

1. CMS-1770-F, Addendum B multiplied by 2025 conversion factor ($32.35), 2. CMS-1772-FC, Addendum B, 3. CMS-1772-FC, Addendum AA
Note: Payment rates listed represent 2025 Medicare national payment amounts, individual provider payment will vary

Endoscopy procedures are grouped into different “families”, with each family including a base code. The procedures in each family include the value of the base procedure, and the incremental work for the additional diagnostic or therapeutic procedure (e.g. biopsy, snare polypectomy, etc.) performed. The table below shows the respective base procedure for submucosal injection procedures:

BASE PROCEDURE		RELATED PROCEDURE	
CPT	CODE DESCRIPTION	CPT	DESCRIPTION
43191	Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed	43192	Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed	43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance
43235	Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed	43236	Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance
44388	Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed	44404	Colonoscopy through stoma; with directed submucosal injection(s), any substance
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed	45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed	45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance
		45390	Colonoscopy, flexible; with endoscopic mucosal resection

Source: CMS-1772-F, Addendum B PPRRVU20_Jan.xlsx

For physician services, Medicare has special rules that apply when multiple endoscopic procedures are performed on the same date of service. If the endoscopic procedures are related (i.e. are from the same family), the procedure with the highest value is paid at 100%. The other related endoscopic procedures are paid the difference between its designated payment rate and the payment rate of the base code. If endoscopic procedures are unrelated (i.e. have different base procedures), typical multiple surgical reductions apply (i.e. highest procedure paid at 100%, each additional procedure paid at 50%). The special endoscopy rules are applied first followed by typical multiple procedure reduction for unrelated endoscopies or services. The total payment for each set of endoscopies are treated as one service.[1] For hospital outpatient and ASC services, typical multiple surgical reduction rules apply.[2]

1. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55937&ver=37&=, accessed January 1, 2025
2. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf, accessed January 1, 2025

Procedural Scenarios

For illustrative purposes, three different procedure scenarios using Spot Ex and EverLift are listed with the potential corresponding CPT billing and payment based on where the procedure is performed. Additionally, modifiers may be required to appropriately describe the procedure(s) performed. Modifiers have not been included in these examples. Please check with your payer on the appropriate modifier(s) to utilize based on the characteristics of each case. Please note that these scenarios include payment information based on 2025 Medicare unadjusted national payment rates. Different payers may apply different payment rates and/or multiple surgical reduction rules, and we suggest that providers check with their payers directly to determine their specific reimbursement amounts.

Scenario 1: Diagnostic Colonoscopy with Tattooing

A patient receives a colonoscopy, and the physician utilizes Spot Ex to tattoo a suspicious site in the colon for clinical surveillance.

Place of Service: Non-Facility (Office)

CPT	DESCRIPTION	TOTAL RVUs	PHYSICIAN PAYMENT
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	13.26	$428.91

Place of Service: Hospital Outpatient or ASC

CPT	DESCRIPTION	TOTAL RVUs	PHYSICIAN PAYMENT	HOSPITAL OUTPATIENT	ASC
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	5.88	$190.20	$1,179.08	$632.96

Scenario 2: Polypectomy with Tattooing

A patient receives a colonoscopy, and the physician removes polyps in the ascending colon without a lift technique. The physician uses Spot Ex to tattoo the site for follow-up colonoscopy.

Place of Service: Non-Facility (Office)

CPT	DESCRIPTION	TOTAL RVUs	PHYSICIAN PAYMENT
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	13.60	$439.91
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	13.26	$99.30* ($428.91 - $329.61)
	Total		$539.21

* 2025 Medicare Non-Facility unadjusted national payment rates: CPT 45378: $329.61; Total Non-Facility RVUs=10.19; CPT 45381: $428.91; Total Non-Facility RVUs=13.26

Place of Service: Hospital Outpatient or ASC

CPT	DESCRIPTION	WORK RVUs	PHYSICIAN PAYMENT	HOSPITAL OUTPATIENT	ASC
45385	Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	4.57	$242.28	$1,179.08	$632.96
45381	Colonoscopy, flexible; with directed submucosal injection(s), any substance	3.56	$13.91* ($190.20 - $176.29)	$1,179.08	$632.96
Total			$256.19	$2,358.16	$1,265.92

* 2025 Medicare Facility unadjusted national payment rates: CPT 45378: $176.29 Total Facility RVUs=5.45; CPT 45381: $190.20; Total Facility RVUs=5.88
2025 Medicare Facility unadjusted national Work RVUs: CPT 45378: 3.26; CPT 45381: 3.56

Procedural Scenarios

Scenario 3: Endoscopic Mucosal Resection with Tattooing

A patient receives a colonoscopy, and the physician removes a lesion in the transverse colon via lift technique using EverLift and resection with a snare. The lesion is also tattooed for follow-up colonoscopy. The physician is only able to submit one submucosal injection for payment even though two submucosal injection solutions were used (i.e. EverLift and Spot Ex).

Place of Service: Hospital Outpatient or ASC

CPT	DESCRIPTION	WORK RVUs	PHYSICIAN PAYMENT	HOSPITAL OUTPATIENT	ASC
45390	Colonoscopy, flexible; with endoscopic mucosal resection	6.04	$316.67	$2,742.39	$1,397.97

Frequently Asked Questions

Q. Is there a HCPCS code for Spot Ex or EverLift?

A. There is no HCPCS code specifically for Spot Ex or EverLift. Providers should bill the appropriate CPT code(s) to properly reflect the procedures performed.

Q. Will payers, including Medicare, cover Spot Ex or EverLift?

A. Currently, we are unaware of medical policies that restrict coverage for Spot Ex or EverLift or procedures that typically include Spot Ex or EverLift. Health plans generally cover procedures that are considered reasonable and medically necessary. We suggest contacting the patient's specific payer to understand their coverage guidelines for a particular item or service in advance of performing the procedure.

Q. Why is there no ASC payment for the unlisted procedures above?

A. For Medicare claims, procedures described by unlisted CPT codes are excluded from ASC payment.

Q. Which modifiers should be used when billing CPT codes?

A. Modifiers are utilized to help describe specific circumstances related to the patient. The appropriate modifiers to potentially utilize will depend on the patient's condition, the procedure(s) being performed and payer-specific billing policies.

Q. Does Medicare pay separately for the use of Spot Ex or EverLift?

A. Medicare reimbursement is based on the procedure performed. CPT coding of submucosal injection includes when Spot Ex is utilized for tattooing or EverLift is used for lifting, and the payment rates are inclusive.

Q. Which CPT code do I use for billing when Spot Ex or EverLift is utilized?

A. The correct CPT code is based on where the submucosal injection procedure is performed. The AMA provides additional information and clarification on correct CPT coding, including in the CPT 2023 Professional Edition that provides a Colonoscopy Decision Tree, which may be useful. We suggest contacting your billing staff for additional information on the most appropriate CPT codes to utilize.

Q. Do I get paid separately when Spot Ex or EverLift is used in different locations?

A. The payment for Spot Ex and EverLift is incorporated into the various submucosal injection procedure CPT codes listed previously in this guide. These codes are based on the location in the colon where the procedure is being performed. If multiple locations are marked with Spot Ex within the same area in the colon (as defined by CPT coding), the procedure of a submucosal injection is reported only once. If more than one location is marked with Spot Ex or lifted with EverLift in the colon (as defined by CPT coding), the appropriate CPT codes for submucosal injection in the different areas may be reported.

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