Colonoscopy and Upper Endoscopy (EGD) Price Quote

Listed below are the fees associated with the colonoscopy and upper endoscopy (EGD) procedures. While we cannot guarantee the exact dollar amount of your procedure, we hope this tool will serve as a guideline when contacting your insurance company to determine your benefits. We have included the billing (CPT) codes associated with the various procedures as a reference. Furthermore, we have listed the fees for the physician component as well as the facility fees for the use of any of our ambulatory surgical centers (ASCs). This is not a comprehensive list of all procedures we perform; we have only included the most common procedures.

The final cost of your visit cannot be determined until the physician has fully examined you and completed the procedure. It is not uncommon to have biopsies done and/or polyps removed during the procedures. Most patients who have a biopsy taken or a polyp removed have two or three specimens examined by a pathologist. If the pathologist determines that further testing on the specimen(s) is required, special stains or immunochemistry could also be done. This is rare but if it is needed, the associated pathology charge(s) below would apply. In such cases, you will receive separate bills from the pathologist (Hospital Pathology Associates) and/or a bill from the laboratory (Lab Corp) for any blood work done. If an anesthesia team member administers or monitors the sedation medication given during your procedure, there will be additional charges billed. Please check your insurance for specific benefits. The actual allowed amount (the amount of the billed charge deemed payable by an insurance plan) for each charge will be determined by your insurance company.

Insurance coverage for these procedures varies amongst insurers. It is important to check your individual policy and direct any questions to your insurer to determine coverage and your financial responsibility prior to receiving treatment.

Procedures

Billing Code (CPT Code)	Description	MNGI (Physician Fee)	MNGI Endoscopy* (Facility Fee)
45378	Colonoscopy	$845	$1,177
45380	Colonoscopy with biopsy	$918	$1,520
45385	Colonoscopy with polyp	$1,161	$1,520
45380/45385	Colonoscopy with biopsy and polyp	$2,079	$3,040
43235	EGD	$563	$1,167
43239	EGD with biopsy	$636	$1,167
43248	EGD with savary dilatation	$761	$1,167
43249	EGD with balloon dilatation	$704	$2,450

The nature of some procedures may require that the procedure be performed in a hospital. In this case, the facility charge would be determined by the hospital.

Pathology

Billing Code (CPT Code)	Description	Charge Amount
88305	Biopsy (or polyp)** – Technical component	$154 (Each specimen, only if taken)
88312,88313, 88342	Special stains, group I – Technical component	$309-$377 Only billed if specimen requires additional testing)

***If biopsies or polyps are taken during the procedure, there will be additional charges billed by Hospital Pathology Associates for the physician who reads and interprets the specimen slides.*

Anesthesia

Billing Code (CPT Code)	Description	Charge Amount
00813	For Upper Endoscopy and Colonoscopy Procedure	$1,015-$1,450

***The charge amount for anesthesia care is dependent on the length of the procedure, age, and health status of the patient.*

There are times when the procedure may involve removing tissue by several different methods (snare and biopsy), or different methods of treatment (removal of tissue, dilation or injection of different substances, i.e. india ink, saline). If that is the case, the physician will bill several different codes to fully describe the service performed. In addition, the facility fees will also reflect those same codes. The coding guidelines require us to bill all of the codes for both the physician and the facility. For example, if you have a colonoscopy and a biopsy is taken from one area of the colon and a polyp removed from another area, both of the codes 45380 and 45385 will be billed to your insurance company. If you have an EGD and biopsies are taken in the esophagus and/or stomach, and a dilation is done in the esophagus, both of the codes 43239 and either 43248 or 43249 (depending on the method of dilation) will be billed to your insurance company. Generally speaking, having a procedure at an ASC offers a lower cost alternative compared to having the procedure at a hospital. Our ASCs are certified by Medicare and follow strict guidelines for quality and patient safety. State-of-the-art facilities and equipment combined with experienced staff focusing on a small set of procedures offer our patients a very positive care experience. If you have any further questions, please call our Business Office at 612-871-1145.