EvoEndo Frequently Asked Questions

Intended Use / Indications for Use

The EvoEndo® Model LE Gastroscope is intended for the visualization of the upper digestive tract in adults and pediatric patients, specifically for the observation, diagnosis, and endoscopic treatment of the esophagus, stomach, and duodenal bulb in patients over the age of five years. The gastroscope is a sterile single-use device and can be inserted orally or transnasally.

The EvoEndo® Controller is intended for use with an EvoEndo® Endoscope for endoscopic diagnosis, treatment, and video observation.

CPT CODING

1. ***What are the CPT codes for Flexible, Transnasal, Transoral Esophagoscopy, or EGD procedures?***
    a. The *2025 EvoEndo Coding* and *Payment Reference Guide* provides common CPT codes and summaries of procedural vignettes to support code selection.

HOSPITAL REPORTING AND CHARGES

2. ***The EvoEndo Gastroscope is a sterile single-use device. Are there revenue code categories for reporting a sterile single use device?***
    a. Yes. Revenue codes are standardized to indicate broad categories of products and procedures performed and classify the area in which the service was performed. These codes identify cost centers within a hospital for purposes of billing and tracking costs.
    b. Revenue codes are typically designated and assigned charges by departments that are part of revenue management such as hospital billing, finance, or purchasing.
    c. To support applicable revenue code assignment for the EvoEndo Gastroscope, the *2025 EvoEndo Coding and Payment Reference Guide* and *Chargemaster Checklist* are provided with a list of common revenue codes for sterile, single use devices and supplies.
3. ***When establishing charges, what is an important consideration for the hospital departments responsible for this?***
    a. Notification to the above departments with EvoEndo reimbursement reference materials will provide information to support revenue code assignment and establishment of charges in alignment with their cost accounting practices for a sterile single-use device.

PRIOR AUTHORIZATIONS AND APPEALS

4. ***Is it necessary to contact a patient's payer prior to performing an Upper GI diagnostic procedure?***
    a. It is customary for providers to contact the payer to determine if the plan requires a prior authorization, or to request a pre-determination for the procedure.
    b. For payers who do not require prior authorization, as an option, providers can request a voluntary pre-determination. This may allow for a review of the patient case (medical record documentation) on a voluntary basis.

5. ***What information is needed when contacting the payer?***
    a. Patient history of diagnostic tests, and medical and therapeutic management previously tried (conservative treatment, pharmaceuticals, etc.) with results.
    b. Provide Diagnosis codes that will likely be reported.
    c. Description of procedures and CPT codes that will likely be reported.
6. ***What should the provider capture, ask, and document from the prior authorization request?***
    a. Document the payer representative's name, the call reference number, call time and date.
    b. Document patient benefits information (e.g., copayment or coinsurance, remaining deductible, out-of-pocket amounts, if a referral is required from a primary care provider, and network status of the treating physician and facility, etc.).
    c. Request how to submit the medical record, as described above (e.g., by fax or through the payer portal). For faxes, include a cover sheet with patient demographics, insurance card information, a list of enclosures, and number of pages submitted.
    d. Retain the submission confirmation in the patient record.
    e. If the payer denies the procedure, request the denial letter and options for a pre-service appeal or a peer-to-peer review.
7. ***How are pre-service or claims appeals submitted?***
    a. Follow payer instructions and criteria described in the denial letter.
    b. Submit the referenced medical record as above with a corresponding letter of medical necessity, and clinical peer-reviewed literature as applicable.
8. ***If the provider opts not to appeal, what are possible next steps?***
    a. The original denial remains in effect with the health plan.
    b. If the provider opts for an alternative procedure, ensure the medical record documentation supports an alternative procedure and the selected corresponding CPT code(s).

PHYSICIAN RVUS

9. ***Can charges and payments be established for physician work since national RVUs are not assigned to CPT Category III codes?***
    a. Physician charges and RVUs are internally established typically based on 'crosswalking' to similar EGD and Upper GI endoscopies. To support this process, the *2025 EvoEndo Coding* and *Payment Reference Guide* provides a list of CPT codes with physician RVUs.
    b. As CPT Category III codes are common to use when new technologies and procedures are introduced, billing and claims processing departments are familiar with this methodology for both adult and pediatric procedures.
    c. Payments may also be established with a payer either on a case-by-case basis or through contracting. If the payer agrees to cover or allow for the procedure, the payer will establish a payment, typically based on the charge from the provider.