2025 Customer Billing Quick Reference for Hospital Outpatient Departments (HOPDs)

Medicare incremental device reimbursement applicable to LithoVue™ single-use digital flexible ureteroscope and LithoVue™ Elite single-use digital flexible ureteroscope

Transitional Pass-Through (TPT) Payment

The Centers for Medicare & Medicaid Services (CMS) approved a transitional pass-through (TPT) payment category to describe single-use ureteroscopes, such as the LithoVue Single- Use Digital Flexible Ureteroscope or LithoVue Elite Single-Use Digital Flexible Ureteroscope. The new device pass-through code (C1747) can be used to bill for LithoVue Single-Use Digital Flexible Ureteroscope and LithoVue Elite Single-Use Digital Flexible Ureteroscope when used in the treatment of Medicare patients in the hospital outpatient setting. This device- specific payment is in addition to the ureteroscopy procedure payment and is intended to cover the cost of the device. LithoVue Single-Use Digital Flexible Ureteroscope and LithoVue Elite Single-Use Digital Flexible Ureteroscope can have a positive economic impact on hospitals as they eliminate reprocessing costs associated with reusable ureteroscopes.

Transitional Pass-Through Code

HCPCS	OPPS Status Indicator	Long Description
C1747	H*	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)

*C1747 has a Medicare OPPS status indicator of "H" and therefore is not subject to copayment. Medicare patients treated in the hospital outpatient setting will not incur any additional costs for the utilization of LithoVue during a ureteroscopy procedure. †

Reporting for Procedure and Device on a Claim

When physicians perform a ureteroscopy or PCNL procedure on a Medicare patient in the hospital outpatient setting with LithoVue Single-Use Digital Flexible Ureteroscope or LithoVue Elite Single-Use Digital Flexible Ureteroscope, hospitals, if appropriate, may bill:

- **Procedure coding:** Appropriate CPT® code(s) **plus**
- **Device HCPCS code:** C1747
- **Device Revenue Code:** LithoVue Single-Use Digital Flexible Ureteroscope and LithoVue Elite Single-Use Digital Flexible Ureteroscope are insertable single use sterile devices and may be reported using revenue code 0278 - Medical/surgical supplies and devices. §

Medicare follows NUBC guidelines[6] The UB-04 Editor specifically states to use the revenue code 0278 for C1747.[7]

Device Payment for Single-Use Ureteroscopes

- Medicare does not set a specific payment amount for pass-through codes. Rather, payment is based on hospital-reported charges.
- Device payment for single-use ureteroscopes is determined by the hospital's charge for the pass-through device which is adjusted to cost based on an individual hospital's revenue center cost-to-charge ratio (CCR).

Chargemaster Billing Example

For Illustrative Purposes Only

Note: If your facility uses more than one single-use disposable ureteroscope, it's recommended that they be recorded on separate line items on the chargemaster to reflect individual device costs.

CDM #	CPT/ HCPCS Code	Rev Code	Charge Description	Example Unit Charge
2700XXX0	C1747	278	LithoVue Single-Use Digital Flexible Ureteroscope	$5,100.00
2700XXX1	C1747	278	LithoVue Elite Single-Use Digital Flexible Ureteroscope	$8,160.00

Hypothetical Transitional Pass-Through Payment Calculation Example

For Illustrative Purposes Only

CPT® Code 52356: Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)

		Description	Calculation	LithoVue Amount	LithoVue Elite Amount
Transitional Pass-Through Payment	A	Hospital Specific Charges to Medicare for LithoVue Single-Use Digital Flexible Ureteroscope (LV) or LithoVue Elite Single-Use Digital Flexible Ureteroscope (LVE) (Typically, a hospital applies a usual and customary mark- up for devices. This hospital specific example uses a $1,500 cost of LV/$2,400 cost of LVE and hospital specific mark-up of 3.4X)[4]	LV = $1,500 x 3.4 LVE = $2,400 x 3.4	$5,100	$8,160
	B	Hospital Specific Cost-to-Charge ratio (CCR) for billed Revenue Center code (For this example, we are utilizing 0.29 CCR. This ratio will vary by hospital.) [5]		0.29	0.29
	C	**Medicare's calculated Hospital Specific Cost of LV/LVE**	A x B	$1,479	$2,366
	D	2025 Medicare Device Offset Amount for CPT code 52356, ureteroscopy with laser lithotripsy w/ stent.		$571	$571
	E	**TPT payment for LV/LVE for this Example**	C – D	$908	$1,795
Total Procedure Payment	F	Hospital Specific procedure payment for CPT code 52356, ureteroscopy with laser lithotripsy w/ stent. (For this example, we are using the 2025 Medicare National average outpatient Rate[4].)		$5,084	$5,084
Patient Out-Of-Pocket Payment	G	**Patient Out-Of-Pocket Portion of Procedure Payment**	20% x F (Procedure Payment)	$1,017	$1,017
Patient Out-Of-Pocket Payment Device	H	Patient Out-Of-Pocket Portion of Procedure Payment for Device		$0	$0
Total Payment	I	**Hospital Specific total payment for procedure utilizing LV/LVE**	E + F	$5,992	$6,879

Note: Commercial payers are not required to follow CMS payment methodology, however, some may choose to do so. It is recommended to reach out to commercial payers to understand commercial payer reimbursement for LithoVue Single-Use Digital Flexible Ureteroscope and LithoVue Elite Single-Use Digital Flexible Ureteroscope.

IMPORTANT

Why is it important for a hospital to properly set charges for pass-through devices?

It is important not only for the hospital's payment for the device today, but also to ensure that the data CMS has for future rate setting under the outpatient prospective payment system is accurate and reflective of true procedure costs, including the true cost of the device.

For 2025, the OPPS offset amounts for Ureteroscopy and PCNL CPT codes are below and available at:

https://www.cms.gov/license/ama?file=/files/zip/2025-nfrm-opps-addenda.zip (Addendum P)

CPT® Code	Description	CY2025 APC	Device Offset Amount	2025 Medicare National Average Hospital Outpatient Payment[3]
50080	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (e.g., stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)	5376	$1,166	$9,247
50081	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (e.g., stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)	5376	$1,158	$9,247
50575	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with endopyelotomy (includes cystoscopy, ureteroscopy, dilation of ureter and ureteral pelvic junction, incision of ureteral pelvic junction and insertion of endopyelotomy stent)	5375	$894	$5,084
50951	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	5374	$302	$3,449
50953	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	5374	$328	$3,449
50955	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	5375	$397	$5,084
50957	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	5375	$313	$5,084
50961	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	5375	$548	$5,084
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	5374	$192	$3,449
50972	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization, with or without dilation of ureter	5374	$0	$3,449

CPT® Code	Description	CY2025 APC	Device Offset Amount	2025 Medicare National Average Hospital Outpatient Payment3
50974	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	5375	$700	$5,084
50976	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy	5375	$347	$5,084
50980	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	5375	$330	$5,084
52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (e.g., balloon dilation, laser, electrocautery, and incision)	5374	$629	$3,449
52345	Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (e.g., balloon dilation, laser, electrocautery, and incision)	5374	$678	$3,449
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (e.g., balloon dilation, laser, electrocautery, and incision)	5375	$576	$5,084
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	5374	$213	$3,449
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	5374	$363	$3,449
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	5375	$339	$5,084
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	5375	$477	$5,084
52355	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor	5375	$412	$5,084
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)	5375	$571	$5,084
C9761	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if applicable	5376	$1,853	$9,247

For additional coding and reimbursement information, contact your local Field Reimbursement Manager or the Urology Reimbursement Help Desk at UrologyReimbursement@bsci.com

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2. 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.
3. Hospital outpatient payment rates are 2025 Medicare OPPS Addendum B national averages. Source: Centers for Medicare and Medicaid Services. CMS OPPS – November 2024 release, CMS-1809-FC file. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc
4. See https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.1414 (finding a 3.4 national average mark-up by hospitals).
5. See https://www.govinfo.gov/content/pkg/FR-2022-08-10/pdf/2022-16472.pdf 2023 Medicare national average cost to charge ratio for implantable devices.
6. https://www.govinfo.gov/content/pkg/FR-2010-11-24/pdf/2010-27926.pdf Page 27 Accessed December 23, 2024.

Uniform Billing Editor

CPT/HCPCS	Revenue Code
C1734-C1747	0278

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7.

† See https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-FC. Addendum D1
§ CMS Policy: https://www.govinfo.gov/content/pkg/FR-2010-11-24/pdf/2010-27926.pdf Pages 71824 - 71825.

Caution: U.S. Federal law restricts this device to sale by or on the order of a physician.

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