Medicare Incremental Device Reimbursement Applicable to LithoVue™ 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. Effective January 1, 2023, the new device pass-through code (C1747) can be used to bill for LithoVue 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 can have a positive economic impact on hospitals as it eliminates reprocessing costs associated with reusable ureteroscopes.

TRANSITIONAL PASS-THROUGH CODE

HCPCS	STATUS INDICATOR	LONG DESCRIPTOR
C1747	H*	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)

*C1747 has a Medicare 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 procedure on a Medicare patient in the hospital outpatient setting with LithoVue 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 is an insertable single use sterile device and may be reported using revenue code 278 - Medical/surgical supplies and devices; other implants or 272 - Sterile supplies.§

PROCEDURE PAYMENTS

CPT CODE[1]	AMBULATORY PAYMENT CLASSIFICATION (APC)[2]	2023 MEDICARE NATIONAL AVERAGE HOSPITAL OUTPATIENT PAYMENT[3]
50951, 50953, 50970, 50972, 52344, 52345 52351, 52352	5374 – Level 4 Urology and Related Services	$3,205
50575, 50955, 50957, 50961, 50974, 50976, 50980, 52346, 52353-52356	5375 – Level 5 Urology and Related Services	$4,702
50080, 50081, C9761	5376 – Level 6 Urology and Related Services	$8,557

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 utereroscopes is determined by the hospital's charge for the pass-through device and is adjusted to cost based on an individual hospital's revenue center cost-to-charge ratio (CCR).

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	Amount
Transitional Pass-Through Payment	**A**	Hospital Specific Charges to Medicare for LithoVue Single-Use Digital Flexible Ureteroscope (C1747) (Typically, a hospital applies a usual and customary mark-up for devices. This hospital specific example uses a $1,500 cost of LithoVue Single-Use Digital Flexible Ureteroscope and hospital specific mark-up of 3.4X)[4]	**($1,500 x 3.4)**	$5,100
	B	Hospital Specific Cost-to-Charge ratio (CCR) for Revenue Center 278 or 272 (For this example, we are utilizing 0.29 CCR. This ratio will vary by hospital.) [5]		0.29
	C	Medicare's calculated Hospital Specific Cost of LithoVue Single-Use Digital Flexible Ureteroscope	**A x B**	$1,479
	D	Medicare Device Offset Amount for CPT code 52356, ureteroscopy with laser lithotripsy w/ stent.		$474
	E	**TPT payment for LithoVue Single-Use Digital Flexible Ureteroscope for this Example**	**C - D**	**$1,005**
Procedure Payment	**F**	Hospital Specific procedure payment for CPT code 52356, ureteroscopy with laser lithotripsy w/ stent. (For this example, we are using the 2023 Medicare National average outpatient rate.)		$4,702
Total Payment	**G**	**Hospital Specific payment for procedure utilizing LithoVue Single-Use Digital Flexible Ureteroscope**	**E + F**	**$5,707**

Note: Commercial payers are not required to follow CMS payment levels, 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.

IMPORTANT

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

Proper setting of charges for pass-through devices 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 2023, the CMS device offset amounts for Ureteroscopy CPT codes are below and available at: https://www.cms.gov/license/ama?file=/files/zip/2023-nfrm-opps-addenda.zip (Addendum P)

CPT CODE	DESCRIPTION	CY2023 APC	DEVICE OFFSET AMOUNT	2023 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 (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)	5376	$1,050.86	$8,558
50081	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)	5376	$1,026.05	$8,558
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	$570.84	$4,702
50951	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	5374	$169.87	$3,205
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	$442.95	$3,205
50955	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	5375	$423.20	$4,702
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	$416.14	$4,702
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	$461.75	$4,702
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	5374	$312.82	$3,205
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	$760.57	$3,205
50974	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	5375	$1,069.75	$4,702

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	$2,043.10	$4,702
50980	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	5375	$405.33	$4,702
52344	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (e.g., balloon dilation, laser, electrocautery, and incision)	5374	$507.69	$3,205
52345	Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (e.g., balloon dilation, laser, electrocautery, and incision)	5374	$511.54	$3,205
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (e.g., balloon dilation, laser, electrocautery, and incision)	5375	$602.82	$4,702
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	5374	$169.55	$3,205
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	5374	$320.51	$3,205
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	5375	$252.04	$4,702
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	5375	$428.37	$4,702
52355	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor	5375	$371.94	$4,702
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)	5375	$474.45	$4,702
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	$789.86	$8,557

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 https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-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.
† See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/cms-1772-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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