What does the New Transitional Pass-Through Device Payment Category Mean for BD Aptra™ Single-Use Digital Flexible Ureteroscope in ASCs?

Transitional Pass-Through (TPT) Payment

Effective January 1, 2023, a newly created Level II HCPCS Code (C1747) can be used to bill for Aptra™ Single-Use Digital Flexible Ureteroscope. This code is intended to be used for the actual device in the ambulatory surgical center (ASC) setting for Medicare patients and may be billed in addition to the ureteroscopy procedure.

TPT Code		
HCPCS	**Payment Indicator**	**Long Descriptor**
C1747	J7	Endoscope, single use (i.e., disposable), urinary tract, imaging/illumination device (insertable)

Payment indicator J7 reference: https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1772-fc (Addendum DD1)

Explanations of Certain Terms/Definitions Related to C1747		
HCPCS	**Long Descriptor**	**Action**
C1747	Endoscope, single use (i.e., disposable), urinary tract, imaging/illumination device (insertable)	Single-use (i.e., disposable) endoscope with imaging, illumination, and working channels. This single-use (i.e., disposable) endoscope may be used for procedures specifying ureteral endoscopy.

Reference: https://www.cms.gov/files/document/r11801cp.pdf

Ureteroscopy procedures for Medicare patients using Aptra™ and performed in the ASC setting may request reimbursement by billing:

1. **Appropriate CPT code(s) at the discretion of the provider** (subject to device offset)
2. **Device HCPCS code:** C1747 *must be included to bill for device
3. **Invoice/Cost information:** Pass-through devices are contractor-priced in the ASC setting based on invoice or cost. See specific Medicare Administrative Contractor (MAC) documentation requirements.

*The TPT payment category is effective January 1, 2023, and is anticipated to last a minimum of 2, but no more than 3 years.

ASC Transitional Pass-Through Payment - Example

Description			Calculation	Amount
Transitional Pass-Through Payment	A.	ASC invoice cost for Aptra™ Single-Use Digital Flexible Ureteroscope (C1747)		$1,275.00
Procedure Payment	B.	ASC procedure payment for CPT code 52356 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type))		$2,263.42
	C.	Device offset procedure percent multiplier for C1747/CPT 52356 code pair		0.1015
	D.	Device offset/reduction	$2,263.42 x 0.1015 **(B x C)**	$229.74
	E.	Offset-adjusted payment for CPT code 52356	$2,263.42 - $229.74 **(B - D)**	$2,033.68
Total Payment	F.	ASC payment for procedure (CPT code 52356) utilizing Aptra™ Single-Use Digital Flexible Ureteroscope	$1,275.00 + $2,033.68 **(A + E)**	**$3,308.68**

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New device category HCPCS code C1747 should always be billed with one of the following CPT codes[1]:

- Final CY 2023 APC Payment Rate reference: January 2023 ASC Approved HCPCS Code and Payment Rates - Updated 01/09/2023, https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/11_addenda_updates
- ASC Procedure Percent Multiplier reference: ASC Code Pair File, https://www.cms.gov/medicare/ambulatory-surgical-center-asc-payment/asc-code-pairs

CPT Code	Long Descriptor	2023 ASC Procedure Payment	ASC Procedure Percent Multiplier with C1747
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)	$2,263.42	0.1352
50951	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	$1,496.39	0.0307
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	$1,496.39	0.1399
50955	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	$2,263.42	0.0884
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	$2,263.42	0.0559
50961	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	$2,263.42	0.0818
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	$1,496.39	0.0000
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	$1,496.39	0.0000
50974	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy	$2,263.42	0.0000
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	$2,263.42	0.4345

[1] Per https://www.cms.gov/files/document/r11737cp.pdf.

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50980	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus	$2,263.42	0.0077
52344	Cysto/uretero stricture tx	$1,496.39	0.1023
52345	Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)	$1,496.39	0.1971
52346	Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)	$2,263.42	0.0014
52351	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic	$1,496.39	0.0536
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	$1,496.39	0.0645
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	$2,263.42	0.0493
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	$2,263.42	0.0574
52355	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor	$2,263.42	0.0802
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, gibbons or double-j type)	$2,263.42	0.1015
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	$4,280.49	0.0432

For questions regarding reimbursement for the BD Aptra™ Single-Use Ureteroscope, please contact- reimbursementsupport@bd.com.

This is not a comprehensive list of codes. Coding constantly changes so please reference the AMA and CMS websites www.cms.gov; www.ama-assn.org and your local providers for additional information. We cannot instruct a provider how to bill. We can only provide possible codes that may be appropriate for the activities performed on a particular patient on a particular date of service which are fully supported by detailed notes in the patient's medical record. The provider of service must ascertain which codes are appropriate for the activities actually performed. The reimbursement information presented is for illustrative purposes only and does not constitute reimbursement or legal advice. The company does not guarantee that the use of any of the codes noted will ensure coverage or payment at any particular level. It is the provider's sole responsibility to determine medical necessity and to in turn identify which codes to report and to submit accurate claims. Physicians and hospitals should confirm with a particular payer or coding authority, such as the American Medical Association or medical specialty society, which codes or combinations of codes are appropriate for a particular procedure or combination of procedures. Reimbursement rules vary widely by insurer so the provider should understand and comply with any specific rules that may be set by a patient's insurer, including the complex rules of Medicare and Medicaid. Under no circumstances will the company or its employees, consultants agents, or representatives be liable for costs, expenses, losses, claims, liabilities or other damages (whether direct, indirect, special, incidental, consequential or otherwise) that may arise from or be incurred in connection with this information or any use thereof. BD does not guarantee that the procedures described herein will be reimbursable in whole or in part, by any public or private payor, including Medicare. BD specifically excludes any representation or warranty relating to reimbursement. **Please consult product labels and inserts for any indications, contraindications, hazards, warnings, precautions and instructions for use.**

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For more information, see examples of MAC ASC TPT instructions at:

> *https://www.palmettogba.com/palmetto/jmb.nsf/DIDC/2EN8RXFCNH~Specialties~Ambulatory%20Surgical%20Center*
>
> *https://medicare.fcso.com/Ambulatory_surgical_center/0495578.asp*

Also see 2023 OPPS/ASC rule, https://www.govinfo.gov/content/pkg/FR-2022-11-23/pdf/2022-23918.pdf, page 72082:

> *As previously discussed, devices that are eligible for pass-through payment under the OPPS are separately paid under the ASC payment system and are contractor-priced. Transitional pass-through payments under the OPPS utilize hospital cost-to-charge ratios to reduce the pass-through device to cost and provide the hospital an additional payment of the amount by which cost of the pass-through device exceeds the applicable device offset amount. ASCs do not submit cost reports and, as such, we are unable to replicate the OPPS transitional pass-through payment under the ASC payment system. Currently, MACs have been instructed to pay for such devices in the ASC setting based on invoice or cost.*
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