News

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New Medicare Pass-Through Code for Single-Use Endoscopes

The Centers for Medicare & Medicaid Services (CMS) has <u>released</u> a new device pass-through code (C1748) for single-use endoscopes, for example the EXALT™ Model D Single-Use Duodenoscope. This code is specific to the single-use technology and not the specific model.

C1748 - Endoscope, single-use (i.e. disposable), upper GI, imaging/illumination device (insertable)

Beginning July 1, 2020, hospitals may use C1748 to bill single-use upper GI endoscopes when used in the treatment of Medicare patients in the hospital outpatient setting for endoscopic retrograde cholangiopancreatography (ERCP) procedures. This device-specific payment is in addition to the payment for the following ERCP procedures:

43260	Endoscopic retrograde cholangiopancreatography
	(ERCP); diagnostic, including collection of specimen(s) by
	brushing or washing, when performed (separate
	procedure)
43261	with biopsy, single or multiple
43262	with sphincterotomy/papillotomy
43263	with pressure measurement of sphincter of Oddi
43264	with removal of calculi/debris from biliary/pancreatic
	duct(s)
43265	with destruction of calculi, any method (eg, mechanical,
	electrohydraulic, lithotripsy)
43274	with placement of endoscopic stent into biliary or
	pancreatic duct, including pre- and post-dilation and guide
	wire passage, when performed, including sphincterotomy,
	when performed, each stent
43275	with removal of foreign body(s) or stent(s) from
	biliary/pancreatic duct(s)
43276	with removal and exchange of stent(s), biliary or
	pancreatic duct, including pre- and post-dilation and guide
	wire passage, when performed, including sphincterotomy,
	when performed, each stent exchanged
43277	with trans-endoscopic balloon dilation of biliary/pancreatic
	duct(s) or of ampulla (sphincteroplasty), including
	sphincterotomy, when performed, each duct
43278	with ablation of tumor(s), polyp(s), or other lesion(s),
	including pre- and post-dilation and guide wire passage,
	when performed

What is the reimbursement?

It is important to note that Medicare does not set specific payments for pass-through codes. As per <u>federal</u> <u>regulation</u>, pass-through device payment is the hospital's charge for the device, adjusted to the actual cost for the device, minus the amount included in the APC payment amount for the device, located in Table 9 of <u>CMS Transmittal 10166</u> for C1748.

Thank you for the opportunity to provide feedback. Should you need additional information please contact us directly.







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