PercuVision®

DirectVision®
Be BRILLIANT

DirectVision® Catheter Reimbursement and Related Procedures

Procedure	DirectVision® Visual Catheter Placement with or without a Guidewire[1]	DirectVision® Visual Catheter Placement with Guidewire[1] and Dilation of a Stricture with Dilators (Amplatz type)
CPT Code	52000-52[(2)] Cystourethroscopy (separate procedure) (Do not report 52000 in conjunction with 52001, 52320, 52325, 52327, 52330, 52332, 52334, 52341, 52342, 52343, 52356	52281-52[(2)] Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis with or without meatotomy, with or without injection procedure for cystography, male or female.
APC Code	APC 5372[4] Level II Urology and Related Procedures	APC 5373[4] Level III Urology and Related Procedures
Professional Fee	$105.51[3] Medicare payment	$158.27[3] Medicare payment
Facility Fee	$549.44[5] Medicare reimbursement	$1,644.66[5] Medicare reimbursement

1) A guidewire is a third party product and PercuVision® is not an authorized representative for Boston Scientific.
2) The modifier 52 indicates a partially reduced procedure and in the case of DirectVision® only a Urethroscopy is performed, not a complete diagnostic Cystoscopy which includes the examination of the bladder.
3) Medicare payment based on Medicare calculated rates 3/6/2017 for full value of CPT code listed. Use of modifier -52 may result in lower overall reimbursement. Payment rate includes patient responsibility. No geographic adjustments have been applied.
4) APC from Addendum A OPPS file January 2017 crosswalk to CPT code listed for payment of Ambulatory Surgical Centers.
5) Payment rates based on APC from Addendum A OPPS file January 2017 crosswalk to CPT code listed for payment of Ambulatory Surgical Centers. No geographic adjustments have been applied. The reimbursement to the Hospital under Outpatient payment rates for the APCs listed exceed those listed in this document.

PercuVision provides this information for your convenience only. It is not intended as a recommendation regarding clinical practice. It is the responsibility of the provider to determine coverage and submit appropriate codes, modifiers, and charges for the services rendered. This document provides assistance for FDA approved or cleared indications. Where reimbursement is requested for a use of a product that may be inconsistent, or not expressly specified in the FDA cleared or approved labeling (e.g., instructions for use, operator's manual, or package insert), consult with your billing advisors or payers for advice on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service. Contact your Medicare contractor or other payer for interpretation of coverage, coding, and payment policies.