# 2026 Coding and Reimbursement Guide for Hoover

## INTRODUCTION

The information contained in this document is provided to assist health care providers understand reimbursement guidelines and procedures. It is intended to help obtain accurate coding, coverage and payment for medically necessary health care services provided to patients under physician orders. It is not intended to increase or maximize reimbursement.

The information referenced is based upon coding experience and research of current coding practices and published payer policies. They are based upon commonly used codes and procedures. The final decision for coding of any procedure must be made by the provider of care considering the medical necessity of the services, supplies provided and the regulations of insurance carriers including local, state or federal laws that apply.

Although a particular service or supply may be considered medically necessary by the provider, the final coverage decision is based upon a review of the available clinical information and does not mean the service or supply will be covered by any payer. Each payer and benefit plan contains its own specific provisions for coverage and exclusions. Please consult individual payers to determine policy specific guidelines and whether there are any exclusions or other benefit limitations applicable to a particular service or supply.

## CODING METHODOLOGY

The Physicians' Current Procedural Terminology® (CPT) developed by the American Medical Association (AMA) and HCPCS Level II codes developed by the Centers for Medicare and Medicaid Services (CMS) are listings of descriptive and identifying codes for medical services and procedures performed by health care providers and reported to third party carriers. The codes in the CPT Manual are copyrighted by the AMA and updated annually by the CPT Editorial Panel.

Third party payers have adopted the CPT coding system for use by providers to communicate services provided to patients. Therefore, it is important to identify the various potential combinations of services to accurately adjudicate claims. For this system to be effective, it is essential that the coding description accurately describes what transpired at the patient encounter.

## CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to ensure that payment policies and procedures were standardized for all Medicare Administrative Contractors (MACs) to promote national correct coding methodologies. The coding policies developed are based on coding conventions defined in the AMA's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and reviews of current coding practice.

Procedures should be reported with the CPT/HCPCS codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code or when a single payment episode is split into two or more episodes so multiple payments can be collected.

The NCCI edits have been developed for application to services billed by a single provider for a single patient on the same date of service. The NCCI represents a more comprehensive approach to unifying coding practices. Quarterly updates are available for hospitals and physicians at http://www.cms.hhs.gov/NationalCorrectCodInitEd

Code appropriately based upon procedures performed and medical necessity
Be aware of local coverage policies and correct coding initiative quarterly updates
Payment rates provided are average national Medicare rates
Actual reimbursement will vary by geographic region and payer
Contact local Medicare Administrative Contractor (MAC) for specific coding guidelines
This information is provided for educational purposes only

## HOSPITAL OUTPATIENT (OPPS) AND ASC CODING & REIMBURSEMENT

In the hospital outpatient prospective payment system, CMS assigns all CPT and HCPCS codes a status indicator (SI) which indicates if and how a service is considered for payment. In the Ambulatory Surgical Center (ASC), CMS assigns CPT and HCPCS codes a payment indicator (PI) to indicate how payment is determined. Below is a list of SIs and PIs used in this Guide and their definitions:

| | |
|---|---|
| J1 | Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F, G, H, L and U<br><br>Note: in the ASC, comprehensive APCs do not apply; procedures are paid separately if applicable |
| J8 | Device-intensive procedure; paid at adjusted rate |
| N/N1 | Packaged service/item; no separate payment made |

C9761 was established by The Centers for Medicare & Medicaid Services (CMS) for facilities to report removal of kidney stones using laser lithotripsy with vacuum aspiration.

C1747 may also be reported when a single use ureteroscope is billed to Medicare in the hospital outpatient and ASC. Please note that as of January 1, 2026, there is no longer transitional pass-through payment for C1747; instead, payment is packaged with primary procedure with which it is reported. Providers should continue to report the C1747 to ensure all charges are accurately captured for calculation of future payment rates.

Some private payers accept C9761and/or C1747 while others may advise alternative codes. We advise contacting your local payers to determine or dornier@thepinnaclehealthgroup.com for additional guidance.

| HCPCS | Descriptor | OPPS | | ASC | |
|---|---|---|---|---|---|
| | | SI | Payment | PI | Payment |
| 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 (must use a steerable ureteral catheter) | J1 | $9,672 | J8 | $6,612 |
| C1747 | Endoscope, single use (i.e., disposable), urinary tract, imaging/illumination device (insertable) | N | Packaged | N1 | Packaged‡ |

## PHYSICIAN CODING & REIMBURSEMENT

Providers should report the primary Cystourethroscopy procedure (52353 or 52356) for the Hoover procedure. For the additional work associated with the steerable vacuum aspiration, either the unlisted procedure CPT 53899 may be reported or modifier -22 may be appended to 52353 or 52356 to indicate that the work performed was greater than what is typically required for these procedures. In either scenario, providers should be prepared to provide clinical documentation that describes the procedure if requested by the payer.

| CPT | Descriptor | MPFS |
|---|---|---|
| **Cystourethroscopy & Lithotripsy** | | |
| 52353 | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included) | $344 |
| OR | | |
| 52356 | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (e.g., Gibbons or double-J type) | $365 |
| **Steerable Vacuum & Aspiration of Stone Fragments** | | |
| 53899* | Unlisted procedure, urinary system | By Report |
| OR | | |
| Modifier 22* | Increased procedural services.<br>Should be appended to either CPT 52353 or 52356 | By Report |

* A short description of the extra work performed should be documented and added to Box 19 of the claim to assist in proper processing by the payer

## ICD-10-CM CODING

ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) is a system used by physicians and other healthcare providers to classify and code all diagnoses, symptoms and procedures recorded in conjunction with a patient encounter. The following ICD-10-CM codes may be used with patients undergoing treatment for stone management.

| ICD-10-CM | Descriptor |
|---|---|
| N20.0 | Calculus of kidney |

## REFERENCES


1. CY 2026 Medicare Hosp. OPPS & ASC Payment System Final Rule (CMS-1834-FC); Addendum B and ASC Addenda.
2. CY 2026 Physician Fee Schedule Final Rule (CMS-1832-F); Addendum B. All MPFS Fee Schedules calculated using the Non-Qualifying QP CF of $33.4009.
3. 2026 CPT Professional, ©2025 American Medical Association
4. ICD-10-CM 2026, ©2025 Optum360, LLC. All rights reserved