# SpaceOAR™ and SpaceOAR Vue™ Hydrogel Systems

## 2024 Coding & Payment Quick Reference

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

The following codes are thought to be relevant to SpaceOAR™ and SpaceOAR Vue™ procedures and are referenced throughout this guide.

To determine whether there are relevant C-codes for any Boston Scientific products, please visit our C-code finder at http://www.bostonscientific.com/en-US/reimbursement/ccode-finder.html.

C-Codes are tracking codes established by the Centers for Medicare & Medicaid Services (CMS) to assist Medicare in establishing future APC payment rates. C-Codes only apply to Medicare hospital outpatient claims. They do not trigger additional payment to the facility today.

It is very important that hospitals report C-Codes as well as the associated device costs. This will help inform and potentially increase future outpatient hospital payment rates.

| CPT® / HCPCS Code | Code Description |
|---|---|
| 55874 | Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed |

## Physician Payment – Medicare

All rates shown are **2024 Medicare national averages**; actual rates will vary geographically and/or by individual facility.“Allowed Amount” is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurances, etc.The 2024 National Average Medicare physician payment rates have been calculated using a 2024 conversion factor effective March 9, 2024, of $33.2875. Rates subject to change.

| CPT® / HCPCS Code | Work RVU | Non-Facility Practice Expense RVU | Facility Practice Expense RVU | Malpractice RVU | Total Office-Based RVU | Total Facility-Based RVU | MD In-Office Medicare Allowed Amount | MD In-Facility Medicare Allowed Amount |
|---|---|---|---|---|---|---|---|---|
| 55874 | 3.03 | 81.87 | 1.52 | 0.32 | 85.22 | 4.87 | $2,837 | $162 |

## Hospital Outpatient Payment – Medicare

| CPT® / HCPCS Code | Short Description | Payment Status Indicator | APC | Hospital Outpatient Medicare Allowed Amount |
|---|---|---|---|---|
| 55874* | Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed | J1 | 5375 | $4,935 |

**Considered a device intensive procedure by CMS, SpaceOAR™ material must be reported with device code C1889, on the same claims form as the placement code. See page 2 for more information.*



See important notes on the uses and limitations of this information on page 3.

## ASC Payment – Medicare

| CPT® / HCPCS Code | Short Description | Subject to Multiple Procedure Reduction Indicator | Final Payment Indicator | ASC Medicare Allowed Amount |
|---|---|---|---|---|
| 55874* | Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed | Y | J8 | $3,748 |

**Considered a device intensive procedure by CMS, SpaceOAR™ material must be reported with device code C1889, on the same claims form as the placement code.* *See page 2 for more information.*

## ICD-10 CM Diagnosis Code

| ICD-10 CM Diagnosis Code | Description |
|---|---|
| C61 | Malignant neoplasm of prostate |

## C-Code Information

For all C-Code information, please reference the C-code Finder: http://www.bostonscientific.com/en-US/reimbursement/ccode-finder.html

| Code | Description |
|---|---|
| C1889 | Implantable/insertable device, not otherwise classified |

On claims for Medicare beneficiaries, hospitals should report not only the appropriate CPT® Code, but also C-Code C1889.

- C-Codes are tracking codes established by the Centers for Medicare & Medicaid Services (CMS) to assist Medicare in establishing future APC payment rates. C-Codes only apply to Medicare hospital outpatient claims. They do not trigger additional payment to the facility today.
- It is very important that hospitals report C-Codes as well as the associated device costs. This will help inform and potentially increase future outpatient hospital payment rates.

### Suggested Revenue Codes

| Code | Description |
|---|---|
| 278† | Medical/surgical supplied and devices/other implants |


See important notes on the uses and limitations of this information on page 3.

Physician payment rates are 2024 Medicare national averages. Source: Centers for Medicare and Medicaid Services. CMS Physician Fee Schedule – November 2023 release, CMS-1784-F file. https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f

The 2024 National Average Medicare physician payment rates have been calculated using a 2024 conversion factor effective March 9, 2024, of $33.2875. Rates subject to change.

Hospital outpatient payment rates are 2024 Medicare OPPS Addendum B national averages. Source: Centers for Medicare and Medicaid Services. CMS OPPS – November 2023 release, CMS-1786-FC file. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc

ASC payment rates are 2024 Medicare ASC Addendum AA national averages. ASC rates are from the 2024 Ambulatory Surgical Center Covered Procedures List. Source: Centers for Medicare and Medicaid Services. CMS ASC – November 2023 release, ASC Approved HCPCS Code and Payment Rates https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc

National average (wage index greater than one and hospital submitted quality data and is a meaningful HER user) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor, and capital amounts. Source: August 2023 Federal Register, CMS-1785-CN. FY 2024 rates.

https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page#Tables

ICD-10 MS-DRG definitions from the CMS ICD-10-CM/PCS MS-DRG v38.1 Definitions Manual. Source:

https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/P0001.html

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 services with minor exceptions.

† According to Medicare, devices do not need to remain in the body to be classified as "implants."[1,2]

1 Preamble to the Inpatient Prospective Payment update regulation for FY 2009 (73 FR 48462).

2 Revenue Code 278 - Definition in UB-04 manual, National Uniform Billing Committee Summary, August 2009, Page 5: (a) Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes. Examples of Other Implants (not all-inclusive): Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds.

Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered. It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label. Information included herein is current as of November 2023 but is subject to change without notice. Rates for services are effective January 1, 2024.

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

**Sequestration Disclaimer**
Rates referenced in these guides do not reflect Sequestration or other reductions that may be implemented in 2024.

**CPT® Disclaimer**


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