Boston Scientific
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Prostate Health

2019 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 Prostate Health 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® Code	Code Description
BPH Procedures	
52647	Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)
52648	Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
52649	Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy
Radical Prostatectomy	
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal
55840	Prostatectomy, retropubic radical, with or without nerve sparing
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

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See important notes on the uses and limitations of this information on page 4.

Physician Payment – Medicare

All rates shown are **2019 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.

CPT® Code	Short Descriptor	MD In-Office Medicare Allowed Amount	MD In-Facility Medicare Allowed Amount	Total Office-Based RVUs	Total Facility-Based RVUs
BPH Procedures					
52647	Laser coagulation of prostate	$1,668	$675	46.28	18.74
52648	Laser vaporization of prostate	$1,721	$720	47.74	19.97
52649	Laser enucleation of prostate	N/A	$859	N/A	23.84
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	$1,876	$392	52.05	10.89
Radical Prostatectomy					
55831	Prostatectomy; retropubic, subtotal	N/A	$986	N/A	27.35
55840	Prostatectomy; retropubic radical	N/A	$1,222	N/A	33.91
55842	Prostatectomy; retropubic radical, w/ lymph node biopsy	N/A	$1,223	N/A	33.94
55845	Prostatectomy; retropubic radical, w/ bilateral pelvic lymphadenectomy	N/A	$1,423	N/A	39.48
55866	Laparoscopy, surgical prostatectomy	N/A	$1,506	N/A	41.78

"N/A" indicates that Medicare has not deemed this procedure to be reimbursable in this setting.

Hospital Outpatient and ASC Payment – Medicare

CPT® Code	Short Descriptor	Hospital Outpatient Medicare Allowed Amount	ASC Medicare Allowed Amount
BPH Procedures			
52647	Laser coagulation of prostate	$4,021	$1,912
52648	Laser vaporization of prostate	$4,021	$1,912
52649	Laser enucleation of prostate	$4,021	$1,912
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	$1,740	$785
Radical Prostatectomy			
55831	Prostatectomy; retropubic, subtotal	N/A	N/A
55840	Prostatectomy; retropubic radical	N/A	N/A
55842	Prostatectomy; retropubic radical, w/ lymph node biopsy	N/A	N/A
55845	Prostatectomy; retropubic radical, w/ bilateral pelvic lymphadenectomy	N/A	N/A
55866	Laparoscopy, surgical prostatectomy	$7,742	N/A

"N/A" indicates that Medicare has not deemed this procedure to be reimbursable in this setting.

See important notes on the uses and limitations of this information on page 4.

Hospital Inpatient Payment – Medicare

MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

Possible MS-DRG Assignment	Description	Reimbursement
707	Major male pelvic procedures with complication or comorbidity (CC) / major complication or comorbidity (MCC)	$10,944
708	Major male pelvic procedures without CC/MCC	$8,593
713	Transurethral prostatectomy with CC/MCC	$8,940
714	Transurethral prostatectomy without CC/MCC	$5,562

The patient's medical record must support the existence and treatment of the complication or comorbidity.

ICD-10 CM Diagnosis Codes

ICD-10 CM Diagnosis Code	Description
Radical Prostatectomy	
C61	Malignant neoplasm of prostate
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C79.82	Secondary malignant neoplasm of genital organs
D07.5	Carcinoma in situ of prostate
D40.0	Neoplasm of uncertain behavior of prostate
D49.5	Neoplasm of unspecified behavior of other genitourinary organs
BPH Procedures	
N40.0	Enlarged prostate without lower urinary tract symptoms
N40.1	Enlarged prostate with lower urinary tract symptoms
N40.2	Nodular prostate without lower urinary tract symptoms
N40.3	Nodular prostate with lower urinary tract symptoms

ICD-10 PCS Procedure Codes

ICD-10 PCS Procedure Code	Description
Radical Prostatectomy	
0VT00ZZ	Resection of Prostate, Open Approach
0VT04ZZ	Resection of Prostate, Percutaneous Endoscopic Approach
0VT07ZZ	Resection of Prostate, Via Natural or Artificial Opening
0VT08ZZ	Resection of Prostate, Via Natural or Artificial Opening Endoscopic
BPH Laser Surgery	
0V508ZZ	Destruction of Prostate, Via Natural or Artificial Opening Endoscopic

See important notes on the uses and limitations of this information on page 4.

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 2018 but is subject to change without notice. Rates for services are effective January 1, 2019.

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.

Physician payment rates are 2019 Medicare national averages. Source: Centers for Medicare and Medicaid Services. CMS Physician Fee Schedule – November 2018 release, CMS-1693-F file. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html.

The 2019 National Average Medicare physician payment rates have been calculated using a 2019 conversion factor of $36.0391. Rates subject to change.

Hospital outpatient payment rates are 2019 Medicare OPPS Addendum B national averages. Source: Centers for Medicare and Medicaid Services. CMS OPPS – January 2019 release, CMS-1695-FC file. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending.

ASC payment rates are 2019 Medicare ASC Addendum AA national averages. ASC rates are from the 2018 Ambulatory Surgical Center Covered Procedures List. Source: Centers for Medicare and Medicaid Services. CMS ASC – January 2019 release, CMS-1695-FC file. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1695-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending.

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 ($6,109.24). Source: August 2, 2018 Federal Register, CMS-1694-FR. FY 2019 rates.

ICD-10 MS-DRG definitions from the CMS ICD-10-CM/PCS MS-DRG v36.0 Definitions Manual. Source: https://www.cms.gov/ICD10Manual/version36-fullcode-cms/fullcode_cms/P0001.html

Sequestration Disclaimer
Rates referenced in these guides do not reflect Sequestration, automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2019.

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