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GUIDEPOINT
Reimbursement Resources

Select Bladder Tumor Procedures

2015 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.

For Medicare cases, the physician should bill the code that accurately reflects the largest lesion treated.

For Private Payers, the physicians should sum up the size of all lesions treated, and bill the code that most closely describes the aggregate lesion size.

The following codes are thought to be relevant to bladder tumor procedures and are referenced throughout this guide.

CPT® Code[1]	Code Description
52204	Cystourethroscopy, with biopsy(s)
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)

Physician Relative Value Units (RVUs)

Physician Relative Value Units (RVUs) are based on the Medicare 2015 Physician Fee Schedule effective January 1, 2015.

	Office-Based[1]				Facility-Based			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
52204	2.59	7.54	0.30	**10.43**	2.59	1.20	0.30	**4.09**
52214	3.50	14.72	0.38	**18.60**	3.50	1.18	0.38	**5.06**
52224	4.05	14.98	0.46	**19.49**	4.05	1.37	0.46	**5.88**
52234	**See Note**				4.62	1.95	0.51	**7.08**
52235	**See Note**				5.44	2.26	0.61	**8.31**
52240	**See Note**				7.50	2.96	0.83	**11.29**

Note: There are no current Medicare valuations for CPT Codes 52234, 52235 and 52240 performed in the physician office setting.

See important notes on the uses and limitations of this information on page 2.

Effective: 1JAN2015
Expires: 31DEC2015
URO-303117-AA 03/2015

Payment – Medicare

All rates shown are 2015 Medicare national averages; actual rates will vary geographically and/or by individual facility.

	Physician[1]			Facility	
CPT® Code	MD In-Office Medicare Allowed Amount	MD In-Facility Medicare Allowed Amount[2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
52204	$373	$146	0162	$2,084	$1,143
52214	$665	$181	0162	$2,084	$1,143
52224	$697	$210	0162	$2,084	$1,143
52234	NA[5]	$253	0162	$2,084	$1,143
52235	NA[5]	$297	0162	$2,084	$1,143
52240	NA[5]	$404	0162	$2,084	$1,143

Hospital Inpatient Allowed Amounts – Medicare

ICD-9-CM Procedure Code	ICD-9-CM Diagnosis Code	Possible MS-DRG Assignment[6,7]	Reimbursement
56.0 – Transurethral removal of obstruction from ureter or renal pelvic	592.0 – Calculus of kidney 592.1 – Calculus of ureter 592.9 – Urinary calculus, unspecified	668 – Transurethral procedures with major complication or comorbidity (MCC)	$14,657
		669 – Transurethral procedures with complication or comorbidity (CC)	$7,427
		670 – Transurethral procedures without CC/MCC	$5,254

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 that are rendered. 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.

1. Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2015 revised release, RVU15A file. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU15A.html?DLPage=1&DLSort=0&DLSortDir=descending. The 2015 National Average Medicare physician payment rates have been calculated using a 2014 conversion factor of $35.7547. Rates subject to change.
2. "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-insurance, etc.
3. Hospital outpatient payment rates are 2015 Medicare OPPS Addendum B national averages. Source: CMS OPPS - January 2015 revised release, CMS-1613-CN-Addendum-B_REV file http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2015-Jan-Addendum-B.html?DLPage=1&DLSort=2&DLSortDir=descending.
4. ASC payments rates are 2015 Medicare ASC national averages. ASC rates are from the 2015 Ambulatory Surgical Center Covered Procedures List – Addendum AA. Source: January 2015 revised release, CMS-1613-CN-Addendum-AA-BB-DD1-DD2-EE- file http://www.cms.gov/apps/ama/license.asp?file=/ascpayment/downloads/CMS-1613-CN-CY-2015-Addendum-AA-BB-DD1-DD2-EE.zip
5. "NA" in the 2015 "MD-In-Office Medicare Allowed Amount" column means that there is no in-office differential.
6. National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,865.48). Source: August 22, 2014 Federal Register; CMS-1607-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2015 Rates.
7. The patient's medical record must support the existence and treatment of the complication or comorbidity.

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, 2015.

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Effective: 1JAN2015
Expires: 31DEC2015
MS-DRG Rates Expire: 30SEP2015
URO-303117-AA 03/2015