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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52647</td>
<td>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)</td>
</tr>
<tr>
<td>52648</td>
<td>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)</td>
</tr>
<tr>
<td>52649</td>
<td>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)</td>
</tr>
<tr>
<td>53854</td>
<td>Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy</td>
</tr>
<tr>
<td>55831</td>
<td>Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal</td>
</tr>
<tr>
<td>55840</td>
<td>Prostatectomy, retropubic radical, with or without nerve sparing</td>
</tr>
<tr>
<td>55842</td>
<td>Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)</td>
</tr>
<tr>
<td>55845</td>
<td>Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes</td>
</tr>
<tr>
<td>55866</td>
<td>Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed</td>
</tr>
</tbody>
</table>
## 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.

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

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

## Hospital Outpatient and ASC Payment – Medicare

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

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

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

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

### ICD-10 CM Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10 CM Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C61</td>
<td>Malignant neoplasm of prostate</td>
</tr>
<tr>
<td>C77.5</td>
<td>Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes</td>
</tr>
<tr>
<td>C79.82</td>
<td>Secondary malignant neoplasm of genital organs</td>
</tr>
<tr>
<td>D07.5</td>
<td>Carcinoma in situ of prostate</td>
</tr>
<tr>
<td>D40.0</td>
<td>Neoplasm of uncertain behavior of prostate</td>
</tr>
<tr>
<td>D49.5</td>
<td>Neoplasm of unspecified behavior of other genitourinary organs</td>
</tr>
</tbody>
</table>

#### BPH Procedures

<table>
<thead>
<tr>
<th>ICD-10 CM Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N40.0</td>
<td>Enlarged prostate without lower urinary tract symptoms</td>
</tr>
<tr>
<td>N40.1</td>
<td>Enlarged prostate with lower urinary tract symptoms</td>
</tr>
<tr>
<td>N40.2</td>
<td>Nodular prostate without lower urinary tract symptoms</td>
</tr>
<tr>
<td>N40.3</td>
<td>Nodular prostate with lower urinary tract symptoms</td>
</tr>
</tbody>
</table>

### ICD-10 PCS Procedure Codes

<table>
<thead>
<tr>
<th>ICD-10 PCS Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0VT00ZZ</td>
<td>Resection of Prostate, Open Approach</td>
</tr>
<tr>
<td>0VT04ZZ</td>
<td>Resection of Prostate, Percutaneous Endoscopic Approach</td>
</tr>
<tr>
<td>0VT07ZZ</td>
<td>Resection of Prostate, Via Natural or Artificial Opening</td>
</tr>
<tr>
<td>0VT08ZZ</td>
<td>Resection of Prostate, Via Natural or Artificial Opening Endoscopic</td>
</tr>
</tbody>
</table>

#### BPH Laser Surgery

<table>
<thead>
<tr>
<th>ICD-10 PCS Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0VS08ZZ</td>
<td>Destruction of Prostate, Via Natural or Artificial Opening Endoscopic</td>
</tr>
</tbody>
</table>
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Rates for services are effective January 1, 2019.

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


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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