Boston Scientific
Advancing science for life™

GUIDEPOINT
Reimbursement Resources

AMS 700™ Inflatable Penile Prosthesis
AMS Ambicor™ Inflatable Penile Prosthesis

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 AMS 700™ Inflatable Penile Prosthesis and AMS Ambicor™ Inflatable Penile Prosthesis procedures and are referenced throughout this guide.

CPT® Code[1]	Code Description
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders and reservoir
54406	Removal of all components of a multi-component, inflatable penile prosthesis without replacement of prosthesis
54408	Repair of component(s) of a multi-component, inflatable penile prosthesis
54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component, inflatable penile prosthesis through an infected field at the same operative session; including irrigation and debridement of infected tissue

Physician Relative Value Units (RVUs)

Physician Relative Value Units (RVUs) are based on the Medicare 2016 Physician Fee Schedule effective January 1, 2016.

	Office-Based[1]				Facility-Based			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
54405					14.52	7.08	1.63	**23.23**
54406					12.89	6.64	1.46	**20.99**
54408			**See Note**		13.91	7.20	1.57	**22.68**
54410					15.18	7.79	1.70	**24.67**
54411					18.35	9.06	2.06	**29.47**

Note: There are no current Medicare valuations for these procedures performed in the physician's office setting.

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

Effective: 1JAN2016
Expires: 31DEC2016
US/HCA-00400(3) Jan 2016

Payment – Medicare

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis. All rates shown are 2016 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]
54405	-	$832	5377	$14,088	$11,837
54406	-	$752	5374	$2,243	$1,255
54408	-	$813	5375	$3,394	$1,744
54410	-	$884	5377	$14,088	$11,837
54411	-	$1,056	-	-	-

Hospital Inpatient Allowed Amounts – Medicare

Possible MS-DRG Assignment[7,8]		Reimbursement
709	Penis Procedures w/ CC/MCC	$11,645
710	Penis Procedures w/o CC/MCC	$8,367
673	Other Kidney and Urinary Tract Procedures w/ MCC	$19,816
674	Other Kidney and Urinary Tract Procedures w/ CC	$13,668
675	Other Kidney and Urinary Tract Procedures w/o CC/MCC	$9,208

ICD-10 Diagnostic Code	
N50.1	Vascular disorders of male genital organs
N52.9	Male erectile dysfunction, unspecified
N48.5	Ulcer of penis
N48.82	Acquired torsion of penis
N48.89	Other specified disorders of penis
T83.090A	Other mechanical complication of cystostomy catheter, initial encounter
T83.198A	Other mechanical complication of other urinary devices and implants, initial encounter
T83.29XA	Other mechanical complication of graft of urinary organ, initial encounter
T83.498A	Other mechanical complication of other prosthetic devices, implants and grafts of genital tract, initial
T83.59XA	Infection and inflammatory reaction due to prosthetic device, implant and graft in urinary system, initial encounter
T83.6XXA	Infection and inflammatory reaction due to prosthetic device, implant and graft in genital tract, initial encounter
T83.81XA	Embolism of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.82XA	Fibrosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.83XA	Hemorrhage of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.84XA	Pain from genitourinary prosthetic devices, implants and grafts, initial encounter
T83.85XA	Stenosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.86XA	Thrombosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.89XA	Other specified complication of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.9XXA	Unspecified complication of genitourinary prosthetic device, implant and graft, initial encounter

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

Effective: 1JAN2016
Expires: 31DEC2016
US/HCA-00400(3) Jan 2016

ICD-10 Procedure Code	
0VPS0JZ	Removal of Synthetic Substitute from Penis, Open Approach
0VPS3JZ	Removal of Synthetic Substitute from Penis, Percutaneous Approach
0VPS4JZ	Removal of Synthetic Substitute from Penis, Percutaneous Endoscopic Approach
0VPS7JZ	Removal of Synthetic Substitute from Penis, Via Natural or Artificial Opening
0VPS8JZ	Removal of Synthetic Substitute from Penis, Via Natural or Artificial Opening Endoscopic
0VUS0JZ	Supplement Penis with Synthetic Substitute, Open Approach
0VUS4JZ	Supplement Penis with Synthetic Substitute, Percutaneous Endoscopic Approach
0WQM0ZZ	Repair Male Perineum, Open Approach
0WQM3ZZ	Repair Male Perineum, Percutaneous Approach
0WQM4ZZ	Repair Male Perineum, Percutaneous Endoscopic Approach
0WQMXZZ	Repair Male Perineum, External Approach
0WWM07Z	Revision of Autologous Tissue Substitute in Male Perineum, Open Approach
0WWM0KZ	Revision of Nonautologous Tissue Substitute in Male Perineum, Open Approach
0WWM37Z	Revision of Autologous Tissue Substitute in Male Perineum, Percutaneous Approach
0WWM3KZ	Revision of Nonautologous Tissue Substitute in Male Perineum, Percutaneous Approach
0WWM47Z	Revision of Autologous Tissue Substitute in Male Perineum, Percutaneous Endoscopic Approach
0WWM4KZ	Revision of Nonautologous Tissue Substitute in Male Perineum, Percutaneous Endoscopic Approach

1. Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2016 release, RVU16A file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending
   The 2016 National Average Medicare physician payment rates have been calculated using a 2016 conversion factor of $35.8279. 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 2016 Medicare OPPS Addendum B national averages. Source: CMS OPPS - January 2016 release, CMS-1633-FC https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
4. ASC payments rates are 2016 Medicare ASC national averages. ASC rates are from the 2016 Ambulatory Surgical Center Covered Procedures List – Addendum AA. Source: January 2016 release, CMS-1633-FC; CMS-1607-F2
5. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
6. The patient's medical record must support the existence and treatment of the complication or comorbidity.
7. National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,904.74). Source: August 17, 2015 Federal Register; CMS-1632-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.

Disclaimer
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.

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; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2016.

CPT® Disclaimer
 Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Boston Scientific does not promote the use of its products outside their FDA-approved label.

Boston Scientific
Advancing science for life™

Boston Scientific Corporation
300 Boston Scientific Way
Marlborough, MA 01752
www.bostonscientific.com/reimbursement

Effective: 1JAN2016
Expires: 31DEC2016
MS-DRG Rates Expire: 30SEP2016
US/HCA-00400(3) Jan 2016
U.S. Use Only