

Office Based Procedures 2021 Coding & Payment Quick Reference

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Physician Payment – Medicare

All rates shown are 2021 Medicare national averages; actual rates will vary geographically and/or by individual facility.

CPT® Code	Description	MD In-Office Medicare Allowed Amount	Work RVU	Office-Based Practice RVU	Malpractice RVU	Office-Based Total RVUs
Evaluation and Management						
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	\$74	0.93	1.10	0.09	2.12
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	\$114	1.60	1.51	0.15	3.26

CPT® Code	Description	MD In-Office Medicare Allowed Amount	Work RVU	Office-Based Practice RVU	Malpractice RVU	Office-Based Total RVUs
Evaluation and Management						
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	\$170	2.60	2.04	0.23	4.87
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	\$224	3.50	2.62	0.31	6.43
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	\$23	0.18	0.47	0.01	0.66
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.	\$57	0.70	0.88	0.05	1.63

CPT® Code	Description	MD In-Office Medicare Allowed Amount	Work RVU	Office-Based Practice RVU	Malpractice RVU	Office-Based Total RVUs
Evaluation and Management (Continued)						
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.	\$92	1.30	1.25	0.10	2.65
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	\$131	1.92	1.70	0.14	3.76
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.	\$183	2.80	2.24	0.21	5.25

CPT® Code	Description	MD In-Office Medicare Allowed Amount	Work RVU	Office-Based Practice RVU	Malpractice RVU	Office-Based Total RVUs
Stone Management						
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	\$648	2.90	15.41	0.27	18.58
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	\$318	1.10	7.92	0.10	9.12
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	\$968	4.00	23.39	0.34	27.73
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	\$1,228	5.05	29.70	0.45	35.20
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	\$984	3.75	24.12	0.33	28.20
50435	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	\$634	1.82	16.19	0.15	18.16
50561	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	\$487	7.58	5.50	0.87	13.95

CPT® Code	Description	MD In-Office Medicare Allowed Amount	Work RVU	Office-Based Practice RVU	Malpractice RVU	Office-Based Total RVUs
Stone Management (Continued)						
50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	\$1,098	3.96	27.17	0.34	31.47
50694	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	\$1,221	5.25	29.30	0.45	35.00
50695	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	\$1,474	6.80	34.84	0.59	42.23
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	\$318	2.37	6.46	0.27	9.1
52204	Cystourethroscopy, with biopsy(s)	\$408	2.59	8.80	0.30	11.69
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	\$802	3.50	19.06	0.42	22.98
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	\$835	4.05	19.41	0.46	23.92
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple	\$321	2.81	6.05	0.33	9.19
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	\$490	5.20	8.23	0.62	14.05
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	\$941	6.71	19.50	0.76	26.97
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	\$457	2.82	9.94	0.33	13.09
74420-26	Contrast x-ray urinary tract	\$25	0.52	0.18	0.02	0.72

CPT® Code	Description	MD In-Office Medicare Allowed Amount	Work RVU	Office-Based Practice RVU	Malpractice RVU	Office-Based Total RVUs
Prostate Health						
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)	\$1,702	11.30	36.14	1.34	48.78
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)	\$1,755	12.15	36.73	1.42	50.30
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	\$1,888	5.93	47.49	0.69	54.11
55874	Transperineal placement of biodegradable material, peri- prostatic, single or multiple injection(s), including image guidance, when performed	\$3,261	3.03	90.15	0.27	93.45

CPT® Code	Description	MD In-Office Medicare Allowed Amount	Work RVU	Office-Based Practice RVU	Malpractice RVU	Office-Based Total RVUs
Pelvic Health						
51715	Endoscopic injection of implant material into urethra and/or bladder neck	\$376	3.73	6.58	0.48	10.79
L8606	Injectable bulking agent, synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies	\$220	#N/A	#N/A	#N/A	#N/A

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

Physician payment rates are 2021 Medicare national averages. Source: Centers for Medicare and Medicaid Services. CMS Physician Fee Schedule – December 2020 release, CMS-1734-F file. <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-federal-regulation-notices/cms-1734-f>

The 2021 National Average Medicare physician payment rates have been calculated using a 2021 conversion factor of \$34,8931. Rates subject to change.

Hospital outpatient payment rates are 2021 Medicare OPPS Addendum B national averages. Source: Centers for Medicare and Medicaid Services. CMS OPPS – December 2020 release, <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/hospital-outpatient-regulations-and-notices/cms-1736-fc>

ASC payment rates are 2021 Medicare ASC Addendum AA national averages. ASC rates are from the 2021 Ambulatory Surgical Center Covered Procedures List. Source: Centers for Medicare and Medicaid Services. CMS ASC – December 2020 release, CMS-1736-FC file. <https://www.cms.gov/medicare/medicare-fee-service-payment/ascpaymentasc-regulations-and-notices/cms-1736-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 (\$6,427.61). Source: <https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipp-pps-final-rule-home-page>

ICD-10 MS-DRG definitions from the CMS ICD-10-CM/PCS MS-DRG v37.0 Definitions Manual. Source: https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/P0001.html

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 2020 but is subject to change without notice. Rates for services are effective January 1, 2021.

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, 2021.

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