Rezūm
2020 Procedural Payment Guide

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- Hospital Inpatient Codes and Payments
- Outpatient Codes and Payments (Hospital, OBL, ASC)
- Physician Payment and RVUs

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Rezūm™ System
2020 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 Rezūm™ procedures and are referenced throughout this guide.

### Hospital Outpatient and ASC Payment – Medicare

All rates shown are 2020 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>Work RVU</th>
<th>Non-Facility Practice Expense-RVU</th>
<th>Facility Practice Expense RVU</th>
<th>Malpractice RVU</th>
<th>Total Office-Based RVU</th>
<th>Total Facility-Based RVU</th>
<th>MD In-Office Medicare Allowed Amount</th>
<th>MD In-Facility Medicare Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>53854</td>
<td>5.93</td>
<td>44.60</td>
<td>4.23</td>
<td>0.65</td>
<td>51.18</td>
<td>10.81</td>
<td>$1,847</td>
<td>$390</td>
</tr>
</tbody>
</table>

### Physician Payment – Medicare

All rates shown are 2020 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>APC</th>
<th>Code Description</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>53854</td>
<td>5373 – Level 3 Urology</td>
<td>Transurethral destruction of prostate tissue; by radiofrequency-generated water vapor thermal therapy</td>
<td>$1,771</td>
</tr>
<tr>
<td>53854</td>
<td>N/A</td>
<td>Transurethral destruction of prostate tissue; by radiofrequency-generated water vapor thermal therapy</td>
<td>$790</td>
</tr>
</tbody>
</table>

Note: Private payer payment in the HOPD or ASC setting is subject to the contract between the facility and the payer.
Other Procedures Billing

If conscious sedation is used with Rezūm, CPT codes 99152/99153 or 99156/99157 may be applicable. Please consult the 2020 CPT (Copyright American Medical Association, 2019) for additional coding information contact your Field Market Access Manager.

ICD-10 CM Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10 CM Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N40.1</td>
<td>Benign prostatic hyperplasia with lower urinary tract symptoms</td>
</tr>
<tr>
<td>N40.3</td>
<td>Nodular prostate with lower urinary tract symptoms</td>
</tr>
</tbody>
</table>

Frequently Asked Questions

What CPT Code is Used to Bill for the Rezūm™ System Procedure?
All payers require CPT code 53854 when billing the Rezūm procedure. It is recommended that an insurance verification request be completed by the Rezūm Procedure Reimbursement Hotline prior to treatment. The Rezūm Procedure Reimbursement Hotline staff will contact the payer at your request and report back coverage details.

Does Medicare Reimburse for CPT Code 53854?
Yes, all Medicare contractors reimburse for the Rezūm procedure. Payment varies by geographic locale.

Is Prior Authorization Required for the Rezūm System Procedure?
Medicare does not allow prior authorization; however, some of the private payers will require it. The Rezūm Procedure Reimbursement Hotline staff can confirm and communicate the prior authorization process for the patient’s payer based on the benefit plan.

How is Conscious Sedation Reported if Used in the Physician Office?
If conscious sedation is used in the physician office setting, an independent, trained observer must be present to monitor the patient’s status. If the sedation is administered by the surgeon, it is reported using CPT codes 99152-99153. The intra-service time begins with the administration of the agent and concludes at the end of personal contact with the patient by the physician providing the sedation. Billing of these services requires continuous face-to-face attendance. Coverage and reimbursement for conscious sedation varies by the patient’s benefit plan and should be confirmed prior to the service.

Are Other Procedures Included in the Payment for CPT Code 53854?
Related services are typically considered bundled and included in the payment for the procedure. There is a 90-day global period assigned to CPT code 53854.

Rezūm Procedure Reimbursement Hotline
Hours: 9 a.m. – 6 p.m. ET
Phone: 877-731-9090
Fax: 877-212-5814
E-mail: support@rezumreimbursement.com

The 2020 National Average Medicare physician payment rates have been calculated using a 2020 conversion factor of $36.0896. Rates subject to change.


Comprehensive APCs (C-APCs): In 2014, CMS implemented their C-APC policy with the goal of identifying certain high-cost, device-related outpatient procedures (formerly “device-intensive” APCs). CMS has fully implemented this policy and has identified these high-cost, device-related services as the primary service on a claim. All other services reported on the same date will be considered “adjunctive, supportive, related, or dependent services” provided to support the delivery of the primary service and will be unconditionally packaged into the OPPS C-APC payment of the primary services with minor exceptions.

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.

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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, 2020.

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