Prostate Health

2022 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.

CPT® / HCPCS Code	Code Description
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)
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)
52649	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)
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed

Physician Payment – Medicare

All rates shown are 2022 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.

CPT / HCPCS Code	Short Description	MD In-Office Medicare Allowed Amount	MD In-Facility Medicare Allowed Amount	Total Office-Based RVUs	Total Facility-Based RVUs
52647	Laser coagulation of prostate	$1,647	$657	47.58	18.99
52648	Laser vaporization of prostate	$1,698	$700	49.06	20.24
52649	Laser enucleation of prostate	N/A	$836	N/A	24.15
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	$1,785	$386	51.57	11.14
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	$3,076	$166	88.88	4.79

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

See important notes on the uses and limitations of this information on page 4.

Hospital Outpatient and ASC Payment – Medicare

CPT / HCPCS Code	Short Description	Hospital Outpatient Medicare Allowed Amount	ASC Medicare Allowed Amount
52647	Laser coagulation of prostate	$4,506	$2,113
52648	Laser vaporization of prostate	$4,506	$2,113
52649	Laser enucleation of prostate	$4,506	$2,113
53854*	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	$3,140	$1,430
55874**	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	$4,506	$3,008

**C-Code may be applicable. See page 3 for more information.*
***Considered a device intensive procedure by CMS, SpaceOAR™ material must be reported with device code C1889, on the same claims form as the placement code.*

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	Description	MS-DRG Rate
713	Transurethral prostatectomy with CC/MCC	$9,848
714	Transurethral prostatectomy without CC/MCC	$6,125

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

ICD-10 CM Diagnosis Codes

ICD-10 CM Diagnosis Code	Description
N40.0	Enlarged prostate without lower urinary tract symptoms
N40.1	Enlarged prostate with lower urinary tract symptoms
N40.2	Nodular prostate without lower urinary tract symptoms
N40.3	Nodular prostate with lower urinary tract symptoms
C61	Malignant neoplasm of prostate

ICD-10 PCS Procedure Codes

ICD-10 PCS Procedure Code	Description
BPH Laser Surgery	
0V508ZZ	Destruction of Prostate, Via Natural or Artificial Opening Endoscopic

See important notes on the uses and limitations of this information on page 4

C-Code Information

For all C-Code information, please reference the C-code Finder: http://www.bostonscientific.com/en-US/reimbursement/ccode-finder.html

Code	Description
C1889	Implantable/insertable device, not otherwise classified

On claims for Medicare beneficiaries, hospitals should report not only the appropriate CPT® Code, but also C-Code C1889.

- 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.

Suggested Revenue Code for Device Code C1889

Code	Description
278†	Medical/surgical supplies and devices/other implants

See important notes on the uses and limitations of this information on page 4

Physician payment rates are 2022 Medicare national averages. Source: Centers for Medicare and Medicaid Services. CMS Physician Fee Schedule – Relative Value File December 2021 release, RVU22A file. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

The 2022 National Average Medicare physician payment rates have been calculated using the latest updated 2022 conversion factor of $34.6062. Rates subject to change.

Hospital outpatient payment rates are 2022 Medicare OPPS Addendum B national averages. Source: Centers for Medicare and Medicaid Services. CMS OPPS – November 2021 release, CMS-1753-FC file. https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientpps/cms-1753-fc.

ASC payment rates are 2022 Medicare ASC Addendum AA national averages. ASC rates are from the 2022 Ambulatory Surgical Center Covered Procedures List. Source: Centers for Medicare and Medicaid Services. CMS January 2022 ASC Approved HCPCS Code and Payment Rates – Updated 01/04/2022 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.

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 ($6,594.31). Source: August 2021 Federal Register, CMS-1752-F. FY 2022 rates.

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.

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.

† According to Medicare, devices do not need to remain in the body to be classified as “implants.”[1,2]

1 Preamble to the Inpatient Prospective Payment update regulation for FY 2009 (73 FR 48462).

2 Revenue Code 278 - Definition in UB-04 manual, National Uniform Billing Committee Summary, August 2009, Page 5: (a) Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes. Examples of Other Implants (not all-inclusive): Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds.

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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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, 2022.

CPT® Disclaimer

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Ordering Information
1.888.272.1001

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