GUIDEPOINT Reimbursement Resources

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Prostate Health

2017 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.

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.

The following codes are thought to be relevant to prostate health procedures and are referenced throughout this guide.

CPT® Code	Code Description
BPH Laser Surgery Procedures	
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)
Radical Prostatectomy	
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal
55840	Prostatectomy, retropubic radical, with or without nerve sparing
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed

Physician Payment – Medicare

All rates shown are **2017 Medicare national averages**; actual rates will vary geographically and/or by individual facility.

CPT® Code	Short Descriptor	MD In-Office Medicare Allowed Amount	MD In-Facility Medicare Allowed Amount	Total Office-Based RVUs	Total Facility-Based RVUs
BPH Laser Surgery Procedures					
52647	Laser coagulation of prostate	$1,819	$617	50.69	18.69
52648	Laser vaporization of prostate	$1,872	$715	52.16	19.92
52649	Laser enucleation of prostate	See Note	$853	See Note	23.77
Radical Prostatectomy					
55831	Prostatectomy; retropubic, subtotal	See Note	$980	See Note	27.30
55840	Prostatectomy; retropubic radical	See Note	$1,216	See Note	33.87
55842	Prostatectomy; retropubic radical, w/ lymph node biopsy	See Note	$1,215	See Note	33.86
55845	Prostatectomy; retropubic radical, w/ bilateral pelvic lymphadenectomy	See Note	$1,414	See Note	39.41
55866	Laparoscopy, surgical prostatectomy	See Note	$1,498	See Note	41.74

Note: There are no current Medicare valuations for these codes when performed in the physician office setting.

Hospital Outpatient and ASC Payment – Medicare

CPT® Code	Short Descriptor	Hospital Outpatient Medicare Allowed Amount	ASC Medicare Allowed Amount
BPH Laser Surgery Procedures			
52647	Laser coagulation of prostate	$3,483	$1,739
52648	Laser vaporization of prostate	$3,483	$1,739
52649	Laser enucleation of prostate	$3,483	$1,739
Radical Prostatectomy			
55831	Prostatectomy; retropubic, subtotal	Inpatient Only	Inpatient Only
55840	Prostatectomy; retropubic radical	Inpatient Only	Inpatient Only
55842	Prostatectomy; retropubic radical, w/ lymph node biopsy	Inpatient Only	Inpatient Only
55845	Prostatectomy; retropubic radical, w/ bilateral pelvic lymphadenectomy	Inpatient Only	Inpatient Only
55866	Laparoscopy, surgical prostatectomy	Inpatient Only	Inpatient Only

These procedures are identified by Medicare as "Inpatient Only" procedures and are not approved to be performed in an outpatient setting.

Hospital Inpatient Payment – Medicare

Possible MS-DRG Assignment	Description	Reimbursement
707	Major male pelvic procedures with complication or comorbidity (CC) / major complication or comorbidity (MCC)	$10,789
708	Major male pelvic procedures without CC/MCC	$8,037
713	Transurethral prostatectomy with CC/MCC	$9,511
714	Transurethral prostatectomy without CC/MCC	$5,016

ICD-10 CM Diagnosis Codes

ICD-10 CM Diagnosis Code	Description
Radical Prostatectomy	
C61	Malignant neoplasm of prostate
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C79.82	Secondary malignant neoplasm of genital organs
D07.5	Carcinoma in situ of prostate
D40.0	Neoplasm of uncertain behavior of prostate
D49.5	Neoplasm of unspecified behavior of other genitourinary organs
BPH Laser Surgery	
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

ICD-10 PCS Procedure Codes

ICD-10 PCS Procedure Code	Description
Radical Prostatectomy	
0VT00ZZ	Resection of Prostate, Open Approach
0VT04ZZ	Resection of Prostate, Percutaneous Endoscopic Approach
0VT07ZZ	Resection of Prostate, Via Natural or Artificial Opening
0VT08ZZ	Resection of Prostate, Via Natural or Artificial Opening Endoscopic
BPH Laser Surgery	
0V508ZZ	Destruction of Prostate, Via Natural or Artificial Opening Endoscopic

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.

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1. Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2017 release, RVU17A file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU17A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending The 2017 National Average Medicare physician payment rates have been calculated using a 2017 conversion factor of $35.8887. 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 2017 Medicare OPPS Addendum B national averages. Source: CMS OPPS - January 2017 release, CMS-1656-FC https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
4. ASC payments rates are 2017 Medicare ASC national averages. ASC rates are from the 2016 Ambulatory Surgical Center Covered Procedures List - Addendum AA. Source: January 2017 release, CMS-1656-FC https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1656-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
5. "NA" in the 2017 "MD-In-Office Medicare Allowed Amount" column means that Medicare does not provide reimbursement when the procedure is performed in-office.
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 ($5,962.93). Source: August 2, 2016 Federal Register; CMS-1655-F; CMS-1664-F; CMS-1632-F2; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2017 Rates.

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, 2017.

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Ordering Information
1.888.272.1001

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