BPH Laser Surgery Procedures
2014 Coding and Payment Quick Reference Guide

Boston Scientific

GuidePoint
Simplifying Reimbursement

Urology

CODING

- 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 BPH laser surgery procedures and are referenced throughout this guide.

CPT® Code	Code Description
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)

PHYSICIAN RELATIVE VALUE UNITS (RVUs)

- Physician Relative Value Units (RVUs) are based on the Medicare 2014 Physician Fee Schedule effective January 1, 2014.

	Facility Based				Office Based			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
52648	12.15	6.28	1.15	**19.58**	12.15	37.62	1.15	**50.92**
52649	14.56	7.40	1.35	**23.31**	14.56	NA	1.35	**See Note**

***Note**: There is no current Medicare valuation for CPT Code 52649 performed in the physician office setting.*

See last page for important information about the uses and limitations of this document.

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PAYMENT - MEDICARE

- All rates shown are 2014 Medicare national averages; Actual rates will vary geographically.

PHYSICIAN, HOSPITAL OUTPATIENT & ASC MEDICARE ALLOWED AMOUNTS

	Physician[1]			Facility	
CPT® Code	MD In-Office Medicare Allowed Amount[2]	MD In-Facility Medicare Allowed Amount[2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
52648	$1,824	$701	0429	$3,304	$1,825
52649	NA	$835	0429	$3,304	$1,825

HOSPITAL INPATIENT ALLOWED AMOUNTS - MEDICARE

ICD-9-CM Procedure Code[6]	ICD-9-CM Diagnosis Code[6]	Possible MS-DRG Assignment
60.21 – Transurethral guided laser induced prostatectomy **60.29** – Other transurethral prostatectomy **60.93** – Repair of prostate	**600.0 – 600.91** – Assorted benign prostate diagnoses	**713** – Transurethral prostatectomy, with major complication or comorbidity (CC) / Major complication or comorbidity (MCC) $8,012[7,8] **714** – Transurethral prostatectomy w/o CC/MCC $4,293[8]

ENDNOTES:

[1] Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – December 27, 2013 revised release, RVU14A file. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU14A.html?DLPage=1&DLSort=0&DLSortDir=descending. The 2014 National Average Medicare physician payment rates have been calculated using a 2014 conversion factor of $35.8228 which reflects the 0.5 percent update for January 1, 2014 through March 31, 2014, as adopted by section 101 of the Pathway for SGR Reform Act of 2013. 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] The hospital outpatient payment rates are 2014 Medicare national averages. Source: November 27, 2013 Federal Register, CMS-1601-FC.

[4] The ASC payments rates are 2014 Medicare national averages. ASC rates are from the 2014 Ambulatory Surgical Center Covered Procedures List – Addendum AA. Source: November 27, 2013 Federal Register, CMS-1601-FC.

[5] "NA" in the 2014 "MD-In-Office Medicare Allowed Amount" column means that there is no in-office differential.

[6] "Relevant Procedure/Product" and ICD-9-CM description may not always reflect the exact language of the coding descriptor due to spacing limitations. Use of short layman language titles and/or Boston Scientific's relevant products may be used in place of the coding descriptor.

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

[8] National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,799.59). Source: August 19, 2013 Federal Register; CMS-1599-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2014 Rates.

Sequestration

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, 2014.

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