2025 Coding and Payment Guide – Cystoscopy-Based Procedures

The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. They are thought to be relevant to Cystoscopy-based procedures and are referenced throughout this document. We recommend consulting your relevant manuals for appropriate coding options. Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements.

All rates shown throughout this guide are 2025 Medicare unadjusted national average; 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.

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. (See additional information on page 5).

CPT® codes with their respective long descriptions will be found on page 5.

Physician Payment – Medicare Unadjusted National Average

CPT® Code	Code Description	MD In-Facility Medicare Allowed Amount (NF)	Total Facility Based RVUs (NF)	MD In-Office Medicare Allowed Amount	Total Office Based RVUs
Cystoscopy-based Procedures					
52000	Cystourethroscopy (separate procedure)	$77	2.39	$213	6.59
52001	Cystourethroscopy, with irrigation and evacuation of multiple obstructing clots	$275	8.51	$407	12.59
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	$129	3.98	$275	8.51
52007	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis	$160	4.96	$412	12.73
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service	$160	4.94	$350	10.82
52204	Cystourethroscopy, with biopsy(s)	$136	4.21	$343	10.61
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	$168	5.2	$686	21.21
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	$194	6.01	$718	22.2
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of SMALL bladder tumor(s)	$236	7.3	N/A	N/A
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s)	$277	8.55	N/A	N/A
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of LARGE bladder tumor(s)	$375	11.6	N/A	N/A
52250	Cystourethroscopy, with insertion of radioactive substance, with or without biopsy or fulguration	$230	7.11	N/A	N/A
52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	$202	6.26	N/A	N/A

"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 7.

Physician Payment, continued – Medicare Unadjusted National Average

CPT® Code	Code Description	MD In-Facility Medicare Allowed Amount (NF)	Total Facility Based RVUs (NF)	MD In-Office Medicare Allowed Amount	Total Office Based RVUs
Cystoscopy-based Procedures					
52265	Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia	$157	4.84	$338	10.46
52270	Cystourethroscopy, with internal urethrotomy; female	$175	5.42	$386	11.92
52275	Cystourethroscopy, with internal urethrotomy; male	$239	7.39	$498	15.41
52276	Cystourethroscopy, with direct vision internal urethrotomy	$254	7.85	N/A	N/A
52277	Cystourethroscopy, with resection of external sphincter (sphincterotomy)	$310	9.58	N/A	N/A
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or tenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	$147	4.54	$297	9.18
52282	Cystourethroscopy, with insertion of permanent urethral stent	$323	10	N/A	N/A
52283	Cystourethroscopy, with steroid injection into stricture	$195	6.02	$326	10.08
52285	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone	$190	5.87	$322	9.96
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder (NOTE: See relevant HCPCS code on page 5).	$163	5.04	$355	10.97
52290	Cystourethroscopy, with ureteral meatotomy, unilateral or bilateral	$234	7.24	N/A	N/A
52300	Cystourethroscopy, with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	$268	8.3	N/A	N/A
52301	Cystourethroscopy, with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	$278	8.6	N/A	N/A
52305	Cystourethroscopy, with incision or resection of orifice of bladder diverticulum, single or multiple	$267	8.24	N/A	N/A
52310	With removal of foreign body, calculus, ureteral stent from urethra or bladder (separate procedure); simple	$146	4.52	$292	9.04
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	$263	8.14	$437	13.51
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	$333	10.28	$821	25.39
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	$453	14.02	N/A	N/A
52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	$237	7.32	N/A	N/A
52325	Cystourethroscopy, (Including ureteral catheterization); with fragmentation of ureteral calculus (e.g., ultrasonic or electrohydraulic technique)	$307	9.48	N/A	N/A
52327	Cystourethroscopy (Including ureteral catheterization); with subureteric injection of implant material	$248	7.67	N/A	N/A
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	$253	7.81	$559	17.27
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)	$150	4.64	$363	11.21
52334	Cystourethroscopy, with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	$177	5.46	N/A	N/A

"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 7.

Hospital Outpatient and ASC Payment – Medicare Unadjusted National Average

CPT® Code	Code Description	APC	Hospital Outpatient Status Indicator	Hospital Outpatient Medicare Allowed Amount	ASC Medicare Allowed Amount
Cystoscopy-based Procedures					
52000	Cystourethroscopy (separate procedure)	5372	J1	$667	$316
52001	Cystourethroscopy, with irrigation and evacuation of multiple obstructing clots	5374	J1	$3,449	$1,655
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	5373	J1	$2,049	$960
52007	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis	5374	J1	$3,449	$1,655
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service	5372	J1	$667	$316
52204	Cystourethroscopy, with biopsy(s)	5373	J1	$2,049	$960
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	5374	J1	$3,449	$1,655
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	5374	J1	$3,449	$1,655
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of SMALL bladder tumor(s)	5374	J1	$3,449	$1,655
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s)	5374	J1	$3,449	$1,655
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of LARGE bladder tumor(s)	5375	J1	$5,084	$2,522
52250	Cystourethroscopy, with insertion of radioactive substance, with or without biopsy or fulguration	5374	J1	$3,449	$1,655
52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	5373	J1	$2,049	$960
52265	Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia	5373	J1	$2,049	$230
52270	Cystourethroscopy, with internal urethrotomy; female	5373	J1	$2,049	$960
52275	Cystourethroscopy, with internal urethrotomy; male	5373	J1	$2,049	$960
52276	Cystourethroscopy, with direct vision internal urethrotomy	5373	J1	$2,049	$960
52277	Cystourethroscopy, with resection of external sphincter (sphincterotomy)	5374	J1	$3,449	$1,655
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or tenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	5373	J1	$2,049	$960
52282	Cystourethroscopy, with insertion of permanent urethral stent	5374	J1	$3,449	$1,655
52283	Cystourethroscopy, with steroid injection into stricture	5373	J1	$2,049	$960
52285	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone	5372	J1	$667	$316
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder (NOTE: See relevant HCPCS code on page 5).	5373	J1	$2,049	$960
52290	Cystourethroscopy, with ureteral meatotomy, unilateral or bilateral	5373	J1	$2,049	$960

"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 7.

Hospital Outpatient and ASC Payment, continued – Medicare Unadjusted National Average

CPT® Code	Code Description	APC	Hospital Outpatient Status Indicator	Hospital Outpatient Medicare Allowed Amount	ASC Medicare Allowed Amount
Cystoscopy-based Procedures					
52300	Cystourethroscopy, with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	5374	J1	$3,449	$1,655
52301	Cystourethroscopy, with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	5374	J1	$3,449	$1,655
52305	Cystourethroscopy, with incision or resection of orifice of bladder diverticulum, single or multiple	5375	J1	$5,084	$2,522
52310	With removal of foreign body, calculus, ureteral stent from urethra or bladder (separate procedure); simple	5373	J1	$2,049	$960
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	5373	J1	$2,049	$960
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	5374	J1	$3,449	$1,655
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	5374	J1	$3,449	$1,655
52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	5374	J1	$3,449	$1,655
52325	Cystourethroscopy, (Including ureteral catheterization); with fragmentation of ureteral calculus (e.g., ultrasonic or electrohydraulic technique)	5375	J1	$5,084	$2,522
52327	Cystourethroscopy (Including ureteral catheterization); with subureteric injection of implant material	5375	J1	$5,084	$3,564
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	5374	J1	$3,449	$1,655
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)	5374	J1	$3,449	$1,655
52334	Cystourethroscopy, with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	5374	J1	$3,449	$1,655

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

Hospital Inpatient Payment – Medicare Unadjusted National Average

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.

MS-DRG	Description	Reimbursement
656	Kidney and ureter procedures for neoplasm with MCC	$23,251
657	Kidney and ureter procedures for neoplasm with CC	$13,046
658	Kidney and ureter procedures for neoplasm without CC/MCC	$10,733
659	Kidney and ureter procedures for non-neoplasm with MCC	$18,443
660	Kidney and ureter procedures for non-neoplasm with CC	$9,563
661	Kidney and ureter procedures for non-neoplasm without CC/MCC	$7,326
668	Transurethral procedures with MCC	$20,812
669	Transurethral procedures with CC	$11,044
670	Transurethral procedures without CC/MCC	$6,820

The patient's medical record must support the existence and treatment of the complication or co-morbidity

See important notes on the uses and limitations of this information on page 7.

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	OPPS Status Indicator	Description
C1889	N (packaged)*	Implantable/insertable device, not otherwise classified

*Source:https://www.cms.gov/license/ama?file=/files/zip/2025-nfrm-opps-addenda.zip

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

- 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 and Ambulatory Surgery Center (ASC) claims. They do not trigger additional payment to the facility with the exception of designated transitional pass-through payment (TPT) devices.
- It's important that hospitals report C-Codes as well as the associated device costs as this may help inform more accurate future outpatient hospital payment rates.

Suggested Revenue Code for Device Codes C1889

Code	Description
0278†	Medical/surgical supplies and devices/other implants

CPT® Codes with Long Descriptions

CPT® Code	Long Description
52000	Cystourethroscopy (separate procedure)
52001	Cystourethroscopy, with irrigation and evacuation of multiple obstructing clots
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;
52007	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service
52204	Cystourethroscopy, with biopsy(s)
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)
52250	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52265	Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia
52270	Cystourethroscopy, with internal urethrotomy; female
52275	Cystourethroscopy, with internal urethrotomy; male
52276	Cystourethroscopy with direct vision internal urethrotomy
52277	Cystourethroscopy, with resection of external sphincter (sphincterotomy)
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female
52282	Cystourethroscopy, with insertion of permanent urethral stent
52283	Cystourethroscopy, with steroid injection into stricture

See important notes on the uses and limitations of this information on page 7.

CPT® Codes with Long Descriptions, continued

CPT® Code	Long Description, continued
52285	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder
52290	Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral
52300	Cystourethroscopy; with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral
52301	Cystourethroscopy; with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral
52305	Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)
52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
52325	Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)
52327	Cystourethroscopy (including ureteral catheterization); with subureteric injection of implant material
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
52334	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde

See important notes on the uses and limitations of this information on page 7.

Physician payment rates are 2025 Medicare national averages. Source: Centers for Medicare and Medicaid Services. CMS-1807-F, Physician Fee Schedule – Addendum B, Relative Value File October 2024 release, RVU24D file. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f

The 2025 National Average Medicare physician payment rates have been calculated using a 2025 conversion factor effective January 1, 2025 of $32.3465. Rates subject to change.

Hospital outpatient payment rates are 2025 Medicare OPPS Addendum B national averages. Source: Centers for Medicare and Medicaid Services. CMS OPPS – November 2024 release, CMS-1809-FC file. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc

ASC payment rates are 2025 Medicare ASC Addendum AA national averages. ASC rates are from the 2025 Ambulatory Surgical Center Covered Procedures List. Source: Centers for Medicare and Medicaid Services. CMS ASC November 2024 release, ASC Approved HCPCS Code and Payment Rates https:https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1809-fc

National average (wage index greater than one and hospital submitted quality data and is a meaningful EHR user) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor, and capital amounts. Source: September 30, 2024. Federal Register, CMS-1808-IFC. FY 2025 rates. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page

ICD-10 MS-DRG definitions from the CMS ICD-10-CM/PCS MS-DRG v42.0 Definitions Manual. Source: https://www.cms.gov/icd10m/FY2025-NPRM-Version42-fullcode-cms/fullcode_cms/P0001.html

† 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.

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 or FDA-cleared label. Information included herein is current as of November 2024 but is subject to change without notice. Rates for services are effective January 1, 2025.

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 or other reductions that may be implemented in 2025.

CPT® Disclaimer

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