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GUIDEPOINT
Reimbursement Resources

Select BPH Laser Surgery Procedures

2016 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 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 2016 Physician Fee Schedule effective January 1, 2016.

	Office-Based[1]				Facility-Based[1]			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
52648	12.15	38.24	1.38	**51.77**	12.15	6.31	1.38	**19.84**
52649	**See Note**				14.56	7.43	1.64	**23.63**

Note: There are no current Medicare valuations for CPT Code 52649 performed in the physician office setting.

Payment – Medicare

All rates shown are 2016 Medicare national averages; actual rates will vary geographically.

	Physician[1]			Facility	
CPT® Code	MD In-Office Medicare Allowed Amount[2,5]	MD In-Facility Medicare Allowed Amount[2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
52648	$1,855	$711	5375	$3,394	$1,744
52649	N/A	$847	5375	$3,394	$1,744

See important notes on the uses and limitations of this information on page 2.

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Hospital Inpatient Allowed Amounts – Medicare

ICD-10-PCS Procedure Code	Description
0V508ZZ	Destruction of prostate, via natural or artificial opening endoscopic

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

Possible MS-DRG Assignment[6]	Description	Reimbursement[7]
713	Transurethral prostatectomy, with complication or comorbidity (CC) / major complication or comorbidity (MCC)	$8,903
714	Transurethral prostatectomy without CC/MCC	$4,766

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 2016 release, RVU16A file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending The 2016 National Average Medicare physician payment rates have been calculated using a 2016 conversion factor of $35.8279. 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 2016 Medicare OPPS Addendum B national averages. Source: CMS OPPS - January 2016 release, CMS-1633-FC https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
4. ASC payments rates are 2016 Medicare ASC national averages. ASC rates are from the 2016 Ambulatory Surgical Center Covered Procedures List - Addendum AA. Source: January 2016 release, CMS-1633-FC; CMS-1607-F2 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
5. "NA" in the 2016 "MD-In-Office Medicare Allowed Amount" column means that there is no in-office differential.
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 ($5,904.74). Source: August 17, 2015 Federal Register; CMS-1632-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2015 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, 2016.

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