2025 Coding and Payment Guide – Prostate Health

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 Prostate Health 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 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.

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 2).

CPT® codes with their respective long descriptions will be found on page 3.

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
52647	Laser coagulation of prostate	$635	19.62	$1,463	45.22
52648	Laser vaporization of prostate	$675	20.86	$1,511	46.71
52649	Laser enucleation of prostate	$802	24.79	N/A	N/A
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	$374	11.56	$1,551	47.95
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	$159	4.91	$2,646	81.79

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

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
52647	Laser coagulation of prostate	5375	J1	$5,084	$2,522
52648	Laser vaporization of prostate	5375	J1	$5,084	$2,522
52649	Laser enucleation of prostate	5375	J1	$5,084	$2,522
53854*	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	5374	J1	$3,449	$1,336
55874**	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	5375	J1	$5,084	$3,904

**C-Code may be applicable. See page 2 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.*

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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
713	Transurethral prostatectomy with CC/MCC	$10,319
714	Transurethral prostatectomy without CC/MCC	$6,706

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

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
0V508ZZ	Destruction of Prostate, Via Natural or Artificial Opening Endoscopic

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 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 will help inform and potentially increase future outpatient hospital payment rates.

Suggested Revenue Code for Device Codes C1889

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

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CPT® Codes with Long Descriptions

CPT® Code	Long 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

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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.

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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.

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