Stone Management

2024 Coding & Payment Quick Reference

This procedural reimbursement guide, for select Stone Management procedures, provides coding and reimbursement information for physicians and facilities. The Medicare payment amounts shown are national average payments. Actual reimbursement will vary for each provider and institution based on geographic differences in costs, hospital teaching status, and proportion of low-income patients.

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 Stone Management procedures and are referenced throughout this guide.

CPT® / HCPCS Code	Code Description
Ureteroscopic Stone Management and Stent Insertion	
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)

See important notes on the uses and limitations of this information on page 9.

CPT® Codes (cont'd)

CPT® / HCPCS Code	Code Description
PCNL	
50080	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple
50081	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (e.g., ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (e.g., ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract
50435	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
50436	Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed
50437	Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed; including new access into the renal collecting system
50561	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50605	Ureterotomy for insertion of indwelling stent, all types
50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract
50694	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter
50695	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter
74420	Urography, retrograde, with or without KUB
Bladder Stones	
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)
Select Bladder Tumor Procedures	
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)

See important notes on the uses and limitations of this information on page 10.

Physician Payment – Medicare

All rates shown are 2024 Medicare 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. The 2024 National Average Medicare physician payment rates have been calculated using a 2024 conversion factor effective March 9, 2024, of $33.2875. Rates subject to change.

CPT® / HCPCS Code	Short Description	MD In-Office Medicare Allowed Amount	MD In-Facility Medicare Allowed Amount	Total Office-Based RVUs	Total Facility-Based RVUs
Ureteroscopic Stone Management and Stent Insertion					
52005	Cystourethroscopy, with ureteral catheterization	$303	$131	9.10	3.95
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple	$319	$149	9.58	4.48
52332	Cystourethroscopy, with insertion of indwelling ureteral stent	$399	$153	11.99	4.60
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus	N/A	$347	N/A	10.43
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy	N/A	$384	N/A	11.54
52356	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent	N/A	$407	N/A	12.24
PCNL					
50080	PCNL or pyelostolithotomy; simple; up to 2 cm	N/A	$692	N/A	20.79
50081	PCNL or pyelostolithotomy; complex; over 2 cm	N/A	$1,113	N/A	33.44
50430	Injection procedure for antegrade nephrostogram and/or ureterogram; new access	$623	$150	18.73	4.50
50431	Injection procedure for antegrade nephrostogram and/or ureterogram; existing access	$317	$65	9.53	1.95
50432	Placement of nephrostomy catheter, percutaneous	$890	$198	26.73	5.96
50433	Placement of nephroureteral catheter, percutaneous, new access	$1,108	$246	33.28	7.40
50434	Convert nephrostomy catheter	$889	$185	26.72	5.56
50435	Exchange nephrostomy catheter	$586	$97	17.60	2.92
50436	Dilation of existing tract endourologic percutaneous	N/A	$146	N/A	4.38
50437	Dilation existing tract, new access renal collecting system	N/A	$241	N/A	7.25
50561	Kidney endoscopy & treatment	$475	$387	14.27	11.63
50605	Insert ureteral support	N/A	$1,006	N/A	30.22
50693	Placement ureteral stent percutaneous	$974	$197	29.27	5.93
50694	Placement ureteral stent percutaneous	$1,092	$258	32.82	7.74
50695	Placement ureteral stent percutaneous	$1,312	$331	39.42	9.93
74420	Urography, retrograde, with or without KUB	$78	N/A	2.34	N/A
Bladder Stones					
52317	Litholapaxy; simple or small (<2.5 cm)	$880	$340	26.43	10.20
52318	Litholapaxy; complicated or large (>2.5 cm)	N/A	$464	N/A	13.94
Select Bladder Tumor Procedures					
52204	Cystourethroscopy, with biopsy(s)	$376	$139	11.31	4.19
52214	Cystourethroscopy, with fulguration	$743	$171	22.31	5.15
52224	Cystourethroscopy, with fulguration or treatment of minor (<0.5 cm) lesion(s)	$776	$198	23.31	5.96
52234	Cystourethroscopy, with fulguration and/or resection of small bladder tumor(s) (0.5 - 2.0 cm)	N/A	$241	N/A	7.25
52235	Cystourethroscopy, with fulguration and/or resection of medium bladder tumor(s) (2.0 – 5.0 cm)	N/A	$283	N/A	8.51
52240	Cystourethroscopy, with fulguration and/or resection of large bladder tumor(s)	N/A	$384	N/A	11.55

"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 10.

Hospital Outpatient and ASC Payment – Medicare

CPT® / HCPCS Code	Short Description	Hospital Outpatient Medicare Allowed Amount	Assigned APC	ASC Medicare Allowed Amount
52005	Cystourethroscopy, with ureteral catheterization	$1,943	5373	$930
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); simple	$1,943	5373	$930
52332	Cystourethroscopy, with insertion of indwelling ureteral stent	$3,325	5374	$1,626
52352*	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus	$3,325	5374	$1,626
52353*	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy	$4,935	5375	$2,471
52356*	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent	$4,935	5375	$2,471
PCNL				
50080*	PCNL or pyelostolithotomy; simple, up to 2 cm	$8,787	5376	$4,546
50081*	PCNL or pyelostolithotomy; complex, over 2 cm	$8,787	5376	$4,546
50430	Injection procedure for antegrade nephrostogram and/or ureterogram; new access	$652	5372	N/A
50431	Injection procedure for antegrade nephrostogram and/or ureterogram; existing access	$652	5372	N/A
50432	Placement of nephrostomy catheter, percutaneous	$1,943	5373	$930
50433	Placement of nephroureteral catheter, percutaneous, new access	$3,325	5374	$1,626
50434	Convert nephrostomy catheter	$1,943	5373	$930
50435	Exchange nephrostomy catheter	$1,943	5373	$930
50436	Dilation of existing tract endourologic percutaneous	$3,325	5374	$1,626
50437	Dilation existing tract, new access renal collecting system	$3,325	5374	$1,626
50561	Kidney endoscopy & treatment	$4,935	5375	$2,471
50605	Insert ureteral support	N/A	N/A	N/A
50693	Placement ureteral stent percutaneous	$3,325	5374	$1,626
50694	Placement ureteral stent percutaneous	$3,325	5374	$1,626
50695	Placement ureteral stent percutaneous	$3,325	5374	$1,626
74420	Contrast x-ray urinary tract	$367	5572	N/A
Bladder Stones				
52317	Litholapaxy; simple or small (<2.5 cm)	$3,325	5374	$1,626
52318	Litholapaxy; complicated or large (>2.5 cm)	$3,325	5374	$1,626
Select Bladder Tumor Procedures				
52204	Cystourethroscopy, with biopsy(s)	$1,943	5373	$930
52214	Cystourethroscopy, with fulguration	$3,325	5374	$1,626
52224	Cystourethroscopy, with fulguration or treatment of minor (<0.5 cm) lesion(s)	$3,325	5374	$1,626
52234	Cystourethroscopy, with fulguration and/or resection of small bladder tumor(s) (0.5 - 2.0 cm)	$3,325	5374	$1,626
52235	Cystourethroscopy, with fulguration and/or resection of medium bladder tumor(s) (2.0 – 5.0 cm)	$3,325	5374	$1,626
52240	Cystourethroscopy, with fulguration and/or resection of large bladder tumor(s)	$4,935	5375	$2,471

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

**C-code may be applicable. See page 8 for more information.*

NOTE: The Centers for Medicare & Medicaid Services (CMS) approved a transitional pass-through (TPT) payment category to describe single-use ureteroscopes, such as the LithoVue™ Single-Use Digital Flexible Ureteroscope. Effective January 1, 2023, the new device pass-through code (C1747) can be used to bill for LithoVue Single-Use Digital Flexible Ureteroscope when used in the treatment of Medicare patients in the hospital outpatient setting.

See important notes on the uses and limitations of this information on page 10.

Hospital Inpatient Payment – Medicare

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.

Possible MS-DRG Assignment	Description	MS-DRG Rate
659	Kidney and ureter procedures for non-neoplasm with major complication or comorbidity (MCC)	$18,126
660	Kidney and ureter procedures for non-neoplasm with complication or comorbidity (CC)	$9,423
661	Kidney and ureter procedures for non-neoplasm without CC/MCC	$7,340
668	Transurethral procedures with MCC	$19,731
669	Transurethral procedures with CC	$10,745
670	Transurethral procedures without CC/MCC	$6,740
698	Other kidney and urinary tract diagnoses with MCC	$11,583
699	Other kidney and urinary tract diagnoses with CC	$7,147
700	Other kidney and urinary tract diagnoses without CC/MCC	$4,959

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

ICD-10 CM Diagnosis Codes

ICD-10 CM Diagnosis Code	Description
Bladder Tumors	
C7.0	Malignant neoplasm of trigone of bladder
C67.5	Malignant neoplasm of bladder neck
C67.8	Malignant neoplasm of overlapping sites of bladder
C67.9	Malignant neoplasm of bladder, unspecified
D09.0	Carcinoma in situ of bladder
D30.3	Benign neoplasm of bladder
D41.4	Neoplasm of uncertain behavior of bladder
D49.4	Neoplasm of unspecified behavior of bladder
Bladder and Kidney Stones	
N20.0	Calculus of kidney
N20.1	Calculus of ureter
N20.9	Urinary calculus, unspecified
N21.0	Calculus in bladder

See important notes on the uses and limitations of this information on page 10.

ICD-10 PCS Procedure Codes

ICD-10 PCS Procedure Code	Description
Bladder Tumors	
0T5C8ZZ	Destruction of Bladder Neck, via Natural or Artificial Opening Endoscopic
0T5B8ZZ	Destruction of Bladder, via Natural or Artificial Opening Endoscopic
0TBB8ZX	Excision of Bladder, via Natural or Artificial Opening Endoscopic, Diagnostic
PCNL	
0T9030Z	Drainage of Right Kidney with Drainage Device, Percutaneous Approach
0T9040Z	Drainage of Right Kidney with Drainage Device, Percutaneous Endoscopic Approach
0T9130Z	Drainage of Left Kidney with Drainage Device, Percutaneous Approach
0T9140Z	Drainage of Left Kidney with Drainage Device, Percutaneous Endoscopic Approach
0TC03ZZ	Extirpation of Matter from Right Kidney, Percutaneous Approach
0TC04ZZ	Extirpation of Matter from Right Kidney, Percutaneous Endoscopic Approach
0TC13ZZ	Extirpation of Matter from Left Kidney, Percutaneous Approach
0TC14ZZ	Extirpation of Matter from Left Kidney, Percutaneous Endoscopic Approach
0TC43ZZ	Extirpation of Matter from Left Kidney Pelvis, Percutaneous Approach
0TC44ZZ	Extirpation of Matter from Left Kidney Pelvis, Percutaneous Endoscopic Approach
0TF33ZZ	Fragmentation in Right Kidney Pelvis, Percutaneous Approach
0TF43ZZ	Fragmentation in Left Kidney Pelvis, Percutaneous Approach
0TF44ZZ	Fragmentation in Left Kidney Pelvis, Percutaneous Endoscopic Approach
0TF34ZZ	Fragmentation in Right Kidney Pelvis, Percutaneous Endoscopic Approach
0T9300Z	Drainage of Right Kidney Pelvis with Drainage Device, Open Approach
0T9340Z	Drainage of Right Kidney Pelvis with Drainage Device, Percutaneous Endoscopic Approach
0T9430Z	Drainage of Left Kidney Pelvis with Drainage Device, Percutaneous Approach
0T9440Z	Drainage of Left Kidney Pelvis with Drainage Device, Percutaneous Endoscopic Approach
0TC33ZZ	Extirpation of Matter from Right Kidney Pelvis, Percutaneous Approach
0TC34ZZ	Extirpation of Matter from Right Kidney Pelvis, Percutaneous Endoscopic Approach
0T733D	Dilation of Right Kidney Pelvis with Intraluminal Device, Percutaneous Approach
0T734DZ	Dilation of Right Kidney Pelvis with Intraluminal Device, Percutaneous Endoscopic Approach
0T743DZ	Dilation of Left Kidney Pelvis with Intraluminal Device, Percutaneous Approach
0T744DZ	Dilation of Left Kidney Pelvis with Intraluminal Device, Percutaneous Endoscopic Approach

See important notes on the uses and limitations of this information on page 10.

ICD-10 PCS Procedure Codes (cont'd)

ICD-10 PCS Procedure Code	Description
Bladder Stones	
0TCB7ZZ	Extirpation of Matter from Bladder, Via Natural or Artificial Opening
0TCB8ZZ	Extirpation of Matter from Bladder, Via Natural or Artificial Opening Endoscopic
0TFB0ZZ	Fragmentation in Bladder, Open Approach
0TFB3ZZ	Fragmentation in Bladder, Percutaneous Approach
0TFB4ZZ	Fragmentation in Bladder, Percutaneous Endoscopic Approach
0TFB7ZZ	Fragmentation in Bladder, Via Natural or Artificial Opening
0TFB8ZZ	Fragmentation in Bladder, Via Natural or Artificial Opening Endoscopic
0TFC0ZZ	Fragmentation in Bladder Neck, Open Approach
0TFC3ZZ	Fragmentation in Bladder Neck, Percutaneous Approach
0TFC4ZZ	Fragmentation in Bladder Neck, Percutaneous Endoscopic Approach
0TFC7ZZ	Fragmentation in Bladder Neck, Via Natural or Artificial Opening
0TFC8ZZ	Fragmentation in Bladder Neck, Via Natural or Artificial Opening Endoscopic
0T9B7ZZ	Drainage of Bladder, Via Natural or Artificial Opening
0T9B8ZZ	Drainage of Bladder, Via Natural or Artificial Opening Endoscopic
0T9C7ZZ	Drainage of Bladder Neck, Via Natural or Artificial Opening
0T9C8ZZ	Drainage of Bladder Neck, Via Natural or Artificial Opening Endoscopic
0TCC7ZZ	Extirpation of Matter from Bladder Neck, Via Natural or Artificial Opening
0TCC8ZZ	Extirpation of Matter from Bladder Neck, Via Natural or Artificial Opening Endoscopic
Ureteroscopy	
0TC37ZZ	Extirpation of Matter from Right Kidney Pelvis, Via Natural or Artificial Opening
0TC38ZZ	Extirpation of Matter from Right Kidney Pelvis, Via Natural or Artificial Opening Endoscopic
0TC47ZZ	Extirpation of Matter from Left Kidney Pelvis, Via Natural or Artificial Opening
0TC48ZZ	Extirpation of Matter from Left Kidney Pelvis, Via Natural or Artificial Opening Endoscopic
0TC67ZZ	Extirpation of Matter from Right Ureter, Via Natural or Artificial Opening
0TC68ZZ	Extirpation of Matter from Right Ureter, Via Natural or Artificial Opening Endoscopic
0TC77ZZ	Extirpation of Matter from Left Ureter, Via Natural or Artificial Opening
0TC78ZZ	Extirpation of Matter from Left Ureter, Via Natural or Artificial Opening Endoscopic
0TC68ZZ	Extirpation of Matter from Right Ureter, Via Natural or Artificial Opening Endoscopic
0TC77ZZ	Extirpation of Matter from Left Ureter, Via Natural or Artificial Opening
0TC78ZZ	Extirpation of Matter from Left Ureter, Via Natural or Artificial Opening Endoscopic
0T768DZ	Dilation of Right Ureter with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0T778D	Dilation of Left Ureter with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0T788DZ	Dilation of Bilateral Ureters with Intraluminal Device, Via Natural or Artificial Opening Endoscopic
0TF38ZZ	Fragmentation in Right Kidney Pelvis, Via Natural or Artificial Opening Endoscopic
0TF48ZZ	Fragmentation in Left Kidney Pelvis, Via Natural or Artificial Opening Endoscopic
0TF68ZZ	Fragmentation in Right Ureter, Via Natural or Artificial Opening Endoscopic
0TF78ZZ	Fragmentation in Left Ureter, Via Natural or Artificial Opening Endoscopic

See important notes on the uses and limitations of this information on page 10.

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
C1747	H (transitional pass-through)*	Endoscope, single-use (i.e. disposable), urinary tract, imaging/illumination device (insertable)

*Source: https://www.cms.gov/license/ama?file=/files/zip/2024-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 today.
- It is very important that hospitals report C-Codes as well as the associated device costs. This will help inform and potentially increase future outpatient hospital payment rates.

Suggested Revenue Code for Device Code C1889 and C1747

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

See important notes on the uses and limitations of this information on page 10.

Physician payment rates are 2024 Medicare national averages. Source: Centers for Medicare and Medicaid Services. CMS Physician Fee Schedule – Relative Value File November 2023 release, RVU23A CMS-1784-F file. https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f

The 2024 National Average Medicare physician payment rates have been calculated using a 2024 conversion factor effective March 9, 2024, of $33.2875. Rates subject to change.

Hospital outpatient payment rates are 2024 Medicare OPPS Addendum B national averages. Source: Centers for Medicare and Medicaid Services. CMS OPPS – November 2023 release, CMS-1786-FC file. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc

ASC payment rates are 2024 Medicare ASC Addendum AA national averages. ASC rates are from the 2024 Ambulatory Surgical Center Covered Procedures List. Source: Centers for Medicare and Medicaid Services. CMS ASC November 2023 release, CMS-1786-FC file. ASC Approved HCPCS Code and Payment Rates. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc

National average (wage index greater than one and hospital submitted quality data and is a meaningful EHR user) MSDRG rates calculated using the national adjusted full update standardized labor, non-labor, and capital amounts ($6,497.77). Source: August 2023 Federal Register, CMS-1785-CN. FY 2024 rates. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page#Tables

ICD-10 MS-DRG definitions from the CMS ICD-10-CM/PCS MS-DRG v37.0 Definitions Manual. Source: https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/P0001.html

Comprehensive APCs (C-APCs): In 2014, CMS implemented their C-APC policy with the goal of identifying certain high-cost, device related outpatient procedures (formerly “device intensive” APCs). CMS has fully implemented this policy and has identified these high cost, device-related services as the primary service on a claim. All other services reported on the same date will be considered “adjunctive, supportive, related, or dependent services” provided to support the delivery of the primary service and will be unconditionally packaged into the OPPS C-APC payment of the primary services with minor exceptions.

† 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 2024.

CPT® Disclaimer

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Ordering Information
1.888.272.1001

Effective: 1JAN2024
Expires: 31DEC2024

MS-DRG Rates Expire:
30SEP2024

URO-445005-AF MAR 2024

See important notes on the uses and limitations of this information on page 10.