Cystoscopy-Based Procedures

2024 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 cystoscopy-based procedures and are referenced throughout this guide.

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.

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.

CPT® / HCPCS Code	Code Description
Cystoscopy-based Procedures	
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

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

CPT® Codes (cont'd)

CPT® / HCPCS Code	Code Description
Cystoscopy-based Procedures (continued)	
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
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

C-Code may be applicable. See page 6 for more information.

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
Cystoscopy-based Procedures					
52000	Cystourethroscopy (separate procedure)	$239	$79	7.19	2.38
52001	Cystourethroscopy, with irrigation and evacuation of multiple obstructing clots	$438	$282	13.15	8.47
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	$303	$131	9.1	3.95
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	$448	$164	13.47	4.92
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service	$381	$163	11.45	4.89
52204	Cystourethroscopy, with biopsy(s)	$376	$139	11.31	4.19
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	$743	$171	22.31	5.15
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	$776	$198	23.31	5.96
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of SMALL bladder tumor(s)	N/A	$241	N/A	7.25
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s)	N/A	$283	N/A	8.51
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of LARGE bladder tumor(s)	N/A	$384	N/A	11.55
52250	Cystourethroscopy, with insertion of radioactive substance, with or without biopsy or fulguration	N/A	$235	N/A	7.05
52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	N/A	$207	N/A	6.22
52265	Cystourethroscopy, with dilation of bladder for interstitial cystitis; local anesthesia	$372	$160	11.17	4.81
52270	Cystourethroscopy, with internal urethrotomy; female	$419	$178	12.58	5.36
52275	Cystourethroscopy, with internal urethrotomy; male	$537	$244	16.14	7.32
52276	Cystourethroscopy, with direct vision internal urethrotomy	N/A	$259	N/A	7.79
52277	Cystourethroscopy, with resection of external sphincter (sphincterotomy)	N/A	$317	N/A	9.52
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	$326	$150	9.79	4.5
52282	Cystourethroscopy, with insertion of permanent urethral stent	N/A	$331	N/A	9.94
52283	Cystourethroscopy, with steroid injection into stricture	$353	$198	10.61	5.95
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	$350	$193	10.51	5.8
52287	Cystourethroscopy, with injection(s) for chemodenervation of the bladder (NOTE: See relevant HCPCS code on page 5).	$387	$166	11.62	4.99
52290	Cystourethroscopy, with ureteral meatotomy, unilateral or bilateral	N/A	$239	N/A	7.18
52300	Cystourethroscopy, with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	N/A	$275	N/A	8.25

"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 – Medicare (continued)

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
Cystoscopy-based Procedures					
52301	Cystourethroscopy, with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	N/A	$285	N/A	8.55
52305	Cystourethroscopy, with incision or resection of orifice of bladder diverticulum, single or multiple	N/A	$273	N/A	8.19
52310	With removal of foreign body, calculus, ureteral stent from urethra or bladder (separate procedure); simple	$319	$149	9.58	4.48
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	$469	$269	14.08	8.09
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	$880	$340	26.43	10.20
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	N/A	$464	N/A	13.94
52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	N/A	$241	N/A	7.25
52325	Cystourethroscopy, (Including ureteral catheterization); with fragmentation of ureteral calculus (e.g., ultrasonic or electrohydraulic technique)	N/A	$314	N/A	9.42
52327	Cystourethroscopy (Including ureteral catheterization); with subureteric injection of implant material	N/A	$254	N/A	7.62
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	$601	$258	18.04	7.76
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)	$399	$153	11.99	4.60
52334	Cystourethroscopy, with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	N/A	$179	N/A	5.39

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

Hospital Outpatient and ASC Payment – Medicare

CPT® / HCPCS Code	Short Description	Hospital Outpatient Medicare Allowed Amount	Assigned APC	ASC Medicare Allowed Amount
Cystoscopy-based Procedures				
52000	Cystourethroscopy (separate procedure)	$652	5372	$313
52001	Cystourethroscopy, with irrigation and evacuation of multiple obstructing clots	$3,325	5374	$1,626
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	$1,943	5373	$930
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	$3,325	5374	$1,626
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service	$652	5372	$313
52204	Cystourethroscopy, with biopsy	$1,943	5373	$930
52214	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	$3,325	5374	$1,626
52224	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	$3,325	5374	$1,626
52234	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) and/or resection of SMALL bladder tumor(s)	$3,325	5374	$1,626

CPT® / HCPCS Code	Short Description	Hospital Outpatient Medicare Allowed Amount	Assigned APC	ASC Medicare Allowed Amount
Cystoscopy-based Procedures				
52235	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s)	$3,325	5374	$1,626
52240	Cystourethroscopy with fulguration (including cryosurgery or laser surgery) and/or resection of LARGE bladder tumor(s)	$4,935	5375	$2,471
52250	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration	$3,325	5374	$1,626
52260	Cystourethroscopy with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	$1,943	5373	$930
52265	Cystourethroscopy with dilation of bladder for interstitial cystitis; local anesthesia	$1,943	5373	$256
52270	Cystourethroscopy with internal urethrotomy; female	$1,943	5373	$930
52275	Cystourethroscopy with internal urethrotomy; male	$1,943	5373	$930
52276	Cystourethroscopy with direct vision internal urethrotomy	$1,943	5373	$930
52277	Cystourethroscopy with resection of external sphincter (sphincterotomy)	$3,325	5374	$1,626
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	$1,943	5373	$930
52282	Cystourethroscopy with insertion of permanent urethral stent	$3,325	5374	$1,626
52283	Cystourethroscopy with steroid injection into stricture	$1,943	5373	$930
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	$652	5372	$313
52287	Cystourethroscopy with injection(s) for chemodenervation of the bladder (NOTE: See relevant HCPCS code on page 5).	$1,943	5373	$930
52290	Cystourethroscopy with ureteral meatotomy, unilateral or bilateral	$1,943	5373	$930
52300	Cystourethroscopy with resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	$3,325	5374	$1,626
52301	Cystourethroscopy with resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	$3,325	5374	$1,626
52305	Cystourethroscopy with incision or resection of orifice of bladder diverticulum, single or multiple	$4,935	5375	$2,471
52310	Cystourethroscopy with removal of foreign body, calculus, ureteral stent from urethra or bladder (separate procedure); simple	$1,943	5373	$930
52315	Cystourethroscopy with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	$1,943	5373	$930
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	$3,325	5374	$1,626
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	$3,325	5374	$1,626
52320	Cystourethroscopy with (including ureteral catheterization); with removal of ureteral calculus	$3,325	5374	$1,626
52325	Cystourethroscopy including ureteral catheterization); with fragmentation of ureteral calculus (e.g., ultrasonic or electrohydraulic technique)	$4,935	5375	$2,471
52327	Cystourethroscopy with (including ureteral catheterization); with subureteric injection of implant material	$4,935	5375	$3,468
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	$3,325	5374	$1,626
52332	Cystourethroscopy with insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)	$3,325	5374	$1,626
52334	Cystourethroscopy, with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	$3,325	5374	$1,626

"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 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
656	Kidney and ureter procedures for neoplasm with MCC	$21,968
657	Kidney and ureter procedures for neoplasm with CC	$12,912
658	Kidney and ureter procedures for neoplasm without CC/MCC	$10,365
659	Kidney and ureter procedures for non-neoplasm with MCC	$18,126
660	Kidney and ureter procedures for non-neoplasm with 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

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

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.

On claims for Medicare beneficiaries, hospitals should report not only the appropriate CPT® Code, but also, any appropriate device related C-Code.

- 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

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

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, Addendum B Relative Value Units and Related Information CY 2024 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/license/ama?file=/files/zip/2024-nfrm-opps-addenda.zip

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 November 2023 ASC Approved HCPCS Code and Payment Rates
https://www.cms.gov/license/ama?file=/files/zip/2024-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip

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.

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

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

Boston Scientific
Advancing science for life™

Boston Scientific Corporation
300 Boston Scientific Way
Marlborough, MA 01752-1234
www.bostonscientific.com/reimbursement

Ordering Information
1.888.272.1001

Effective: 1JAN2024
Expires: 31DEC2024
MS-DRG Rates Expire: 30SEP2024
URO-1721903-AA MAR 2024