UROLIFT® BPH Relief. In Sight.™

Commonly Billed Codes 2020

Diagnosis Coding	
ICD-10 Diagnosis Coding	
N40.1	Benign prostatic hyperplasia with lower urinary tract symptoms (LUTS)

Physician Coding: All Sites of Service			
CPT®	**Description**	**OFFICE National Unadjusted Allowed Amount**	**FACILITY National Unadjusted Allowed Amount**
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	$1,397	$219
+52442	Each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	$1,017	$53

Medicare Physician Fee Schedule 2020 National Unadjusted RVUs							
CPT Code	**Global Period**	**Work RVUs**	**PE RVUs FAC**	**PE RVUs Non-FAC**	**Malpract RVUs**	**Total RVUs FAC**	**Total RVUs Non-FAC**
52441	000	4.00	1.60	34.23	0.47	6.07	38.70
+52442	zzz	1.01	0.34	27.06	0.11	1.46	28.18

Facility Coding: Hospital Outpatient or Ambulatory Surgery Center (ASC)		Hospital			ASC	
HCPCS	**Description**	**APC**	**APC Allowed Amount**	**SI**	**Allowed Amount**	**SI**
C9739	Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants	5375	$4,231	J1†	$3,281	J8††
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	5376	$8,067	J1†	$6,908	J8††

Device Code - Hospital Outpatient Only	
HCPCS	**Description**
L8699	Prosthetic implant, not otherwise specified (each implant)

Facility Coding: Alternative Coding for Some Commercial Plans*		Hospital	ASC
CPT®	**Description**	**APC Allowed Amount**	**Allowed Amount**
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Payer Priced	Payer Priced
+52442	Each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Payer Priced	Payer Priced

**While most payers follow Medicare coding guidelines, some payers may prefer the use of the CPT codes normally used for physician billing. Confirm preferred coding with each commercial payer.*

†Comprehensive APC; Payment for all adjunctive services reported on the same claim is packaged into payment for the primary service.

†† Device-intensive procedure; paid at adjusted rate.

Rates referenced in this guide do not reflect sequestration adjustments which are automatic reductions in federal spending that will result in a 2% across-the-board reduction to all Medicare rates as of April 1, 2013. Quoted rates also do not reflect payment adjustments related to quality of and/or meaningful use.

Disclaimer: The information contained in this document was obtained from third-party sources, may not be all-inclusive and is subject to change without notice. Content is informational only and does not constitute medical, legal or reimbursement advice and represents no statement, promise or guarantee of payment. The provider is solely responsible for determining appropriate treatment for the patient based on the unique medical needs of each patient and the independent judgment of the provider. It is also the responsibility of the provider to determine payer appropriate coding, medical necessity, site of service, documentation requirements and payment levels and to submit appropriate codes, modifiers and charges for services rendered. Although we have made every effort to provide information that is current at the time of its issue,it is recommended that you consult your legal counsel, reimbursement/compliance advisor and/or payer organization(s) for interpretation of payer-specific coding, coverage and payment expectations.

NeoTract, Inc. encourages providers to submit claims for services that are appropriately and accurately consistent with FDA clearance and approved labeling and does not promote the use of its products outside their FDA-cleared labeling.

UROLIFT® SYSTEM REIMBURSEMENT SUPPORT

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- All payment levels reflect 2020 Medicare national unadjusted payment rates; payment levels may vary geographically
- Department of Health and Human Services, Centers for Medicare & Medicaid Services. CMS-1715-F: CY 2020. Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Medicare Part B. 1 November 2019. Allowed amounts are calculated with a conversion factor of $36.0896.
- Department of Health and Human Services, Centers for Medicare & Medicaid Services. CMS-1717-FC: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems – Final Rule with Comment Period and CY2020 payment rates.
- With exception of "add-on" coding, multiple procedures furnished during the same operative session may be discounted.
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