

Commonly Billed Codes 2025

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	\$1,162	\$202
+ 52442	Each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	\$792	\$49

Medicare Physician Fee Schedule, 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	1.74	31.41	0.50	6.24	35.91
+ 52442	zzz	1.01	0.37	23.35	0.13	1.51	24.49

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	\$5,084	J1†	\$3,909	J8††	
C9740	Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants	5376	\$9,247	J1†	\$7,820	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	Insurer Priced	Insurer Priced
+ 52442	Each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)	Insurer Priced	Insurer Priced

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

†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 July 1, 2022. Quoted rates also do not reflect payment adjustments related to quality of and/or meaningful use.

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Teleflex LLC. 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.

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- All payment levels reflect 2025 Medicare national unadjusted payment rates; payment levels may vary geographically
- Department of Health and Human Services, Centers for Medicare & Medicaid Services. CMS-1807-F: CY 2025. Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Medicare Part B. November 2024. Allowed amounts are calculated with a conversion factor of \$32.3465.
- Department of Health and Human Services, Centers for Medicare & Medicaid Services. CMS-1809-FC: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems – Final Rule with Comment Period and CY 2025 payment rates.
- With exception of "add-on" coding, multiple procedures furnished during the same operative session may be discounted.
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