# TULSA-PRO®

## 2025 Coding and Billing Guide

The TULSA-PRO Procedure uses a transurethral ultrasound applicator for focused ultrasound ablation of prostate tissue under continuous magnetic resonance (MR) guidance, monitoring, and control. This FDA-cleared device is indicated for transurethral ultrasound ablation (TULSA) of prostate tissue.

The TULSA-PRO procedure is performed in various sites of service that Medicare and many commercial payers pay using different payment methodologies. This document describes codes that facilities commonly use to report the TULSA-PRO procedure when it is furnished in a hospital outpatient department, ambulatory surgical center, and physician office (sometimes referred to as "Officed Based Lab"). It also describes codes that physicians report, including when the services are performed by a single physician and when the services are divided between one physician who specializes in the device management and patient positioning and another that specializes in the image-based treatment and monitoring.

Payer policies vary, and office staff should verify prior to treatment any 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. This information is presented for illustrative purposes only and does not constitute legal or reimbursement advice. It is always the provider's responsibility to determine medical necessity and submit appropriate codes, modifiers, and charges for services rendered that are appropriate to the site of service in which the procedure is furnished. Consult relevant manuals and payer policies for appropriate coding options and guidance.

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This guide was developed to assist professionals and providers who are involved in using or obtaining reimbursement for the TULSA-PRO procedure. It addresses common coverage, coding, and payment issues. Correct claim submissions may reduce requests for additional documentation from payers and mitigate claim denials or payment delays.

PROFOUND

# CODING AND BILLING SUMMARY

| Common ICD-10-CM Diagnosis Code | |
|---|---|
| C61 | Malignant neoplasm of prostate |
| N40.1 | Benign prostatic hyperplasia with lower urinary tract symptoms |
| N40.3 | Nodular prostate with lower urinary tract symptoms |
| R97.21 | Rising PSA following treatment for malignant neoplasm of prostate |

**2025 Relative Value Units (RVU) and Time**

| Code | Global | Work RVUs | NF PE RVUs | Fac PE RVUs | MP RVUs | Total NF RVUs | Total Fac RVUs | Intra-Svc Time | Total Time |
|---|---|---|---|---|---|---|---|---|---|
| 51721 | 000 | 4.05 | 11.70 | 1.92 | 0.50 | 16.25 | 6.47 | 29 mins | 82 mins |
| 55881 | 000 | 9.80 | 252.08 | 3.59 | 1.17 | 263.05 | 14.56 | 120 mins | 202 mins |
| 55882 | 000 | 11.50 | 259.18 | 4.88 | 1.53 | 272.21 | 17.91 | 125 mins | 222 mins |

**Physician Payment Option 1: One Physician**

| Code | Description | 2025 Medicare Ntl. Avg. Physician Payment | |
|---|---|---|---|
| | | Non-Facility (Office) | Facility |
| 55882 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed | $8,805 | $579 |

**Physician Payment Option 1: Two Physicians**

| Code | Description | 2025 Medicare Ntl. Avg. Physician Payment | |
|---|---|---|---|
| | | Non-Facility (Office) | Facility |
| 55881 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation | $8,509 | $471 |
| 51721 | Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed | $526 | $209 |

**HOPD and ASC Payment (Facility)**

| Code | Indicators OPPS \| ASC | | OPPS APC | APC Description | 2025 Medicare Ntl. Avg. Physician Payment | |
|---|---|---|---|---|---|---|
| | | | | | HOPD | ASC |
| 55882 | J1 | J8 | 5377 | Level 7 Urology and Related Services | $12,992 | $10,728 |
| C1889 | No payment but required to be reported on claim to capture device costs | | | | | |

51721 and 55881 are not paid in the HOPD or ASC | J1: All covered Part B services on the claim are packaged with the primary J1 service for the claim, except the Comprehensive APC payment policy exclusions | J8: Device-intensive procedure; paid at adjusted rate | C1889 – Implantable/insertable device, not otherwise classified [to report device]

Note: Physician, OPPS, and ASC payment levels reflect Medicare national average payment levels in effect as of January 1, 2025 (Final Rule). Medicare payments are adjusted geographically and by quality payment reporting.

Disclaimer: The information in this document is provided with the intent to assist in obtaining appropriate payment for medical devices and services. It is NOT intended as legal advice. Seek legal counsel or a reimbursement specialist for further questions or clarifications. The provider makes all decisions concerning completion of claim forms, including code selection and billing amounts. This document is for information purposes only and represents no statement, promise, or guarantee by Profound Medical concerning payment levels.

Providers should select the most appropriate HCPCS / CPT® code(s) with the highest level of detail to describe the service(s) rendered to the patient as well as the most appropriate ICD-10-CM diagnosis code(s) to describe the patient's condition. Any questions should be directed to the pertinent payer.

# INDICATIONS FOR USE

The FDA cleared the TULSA-PRO System via 510(k) on August 15, 2019. The system is indicated for transurethral ultrasound ablation (TULSA) of prostate tissue.

# SYSTEM AND PROCEDURE

The TULSA-PRO system combines real-time Magnetic Resonance (MR) imaging and MR thermometry with transurethral directional ultrasound and closed-loop process control software to deliver precise thermal ablation of a customized volume of prostate tissue. The system consists of both hardware and software components.

Transurethral ultrasound ablation (TULSA) treatment ablates prostate tissue using in-bore real-time MRI treatment planning, monitoring, visualization, and active temperature feedback control. The closed-loop features of the TULSA-PRO software use a real-time MRI interface to process MRI prostate temperature measurements and communicate with the TULSA-PRO hardware, thereby controlling frequency, power, and rotation rate of ultrasound to ablate physician-prescribed prostate tissue with a high degree of precision.

The physician inserts two catheters, one transurethral and another transrectal, into the patient before he is moved into the MR bore. The transurethral catheter consists of an Ultrasound Applicator (UA) which delivers energy from the urethra outwards into the prostate tissue, heating it to thermal coagulation. The transrectal catheter is an Endorectal Cooling Device (ECD) that does not emit any energy and cools the rectal wall adjacent to the prostate. Both catheters have fluid flowing inside throughout the treatment to thermally protect the urethra and rectum. This is done to minimize the potential of any thermal damage to either the urinary or rectal pathways. The physician uses the TULSA-PRO console to robotically position the UA in the prostate and plan the treatment by contouring the prescribed tissue on real-time high-resolution cross-sectional MR images of the prostate. These features provide the physician with the ability and control to customize the treatment plan to minimize thermal impact to critical structures surrounding the prostate, including the external urethral sphincter, rectum, and neurovascular bundles. The treatment begins based upon the physician's instructions by enabling the software to initiate thermal ablation. The TULSA-PRO closed-loop process control software reads real-time MR thermometry measurements and adjusts automatically and dynamically the frequency, power, and rotation rate of ultrasound provided by each UA transducer to deliver precise ablation of the prostate tissue. The software controls automated, continuous, and robotic rotation of the transurethral UA by 360 degrees in sync with the process-controlled delivery of thermal heating to all the intended regions of the prostate. Following completion of the ablation process, the two catheters are removed from the natural orifices of the patients.

## NOTES

# REIMBURSEMENT SUPPORT

Profound Medical has prepared this Billing Guide for coding, reimbursement, and billing personnel at medical facilities and for physicians who perform the TULSA-PRO procedure.

## Coding and Billing Questions

If you have a question about codes, contact us! We are here to provide information to aid proper billing and coding for the TULSA-PRO procedure and to assist in resolving denied claims. Please email **reimbursement@profoundmedical.com** with any questions or to request a meeting to discuss.

## Cost Reporting

It is important to note that all insurance carriers, including Medicare, review payments against the submitted bills they receive for the covered procedure to determine the appropriateness of payment. Therefore, it is important to include all costs incurred when submitting claims to payers, as they will use these claims directly to establish appropriate payment rates in future years.

## Problem Claims

We are here to help you resolve claim issues. Claim issues are inevitable with an emerging product or procedure, and we will help you to resolve general coverage or patient-specific problems.

We will provide you with information to help with appealing denied claims and we will work directly with you to find out why the claim was denied and to help facilitate correct claim processing.

Please email **reimbursement@profoundmedical.com** with any questions or to request a meeting to discuss.

## Additional Resources

Profound has additional resources available upon request.

This includes:

- A sample letter of medical necessity specific to the TULSA-PRO procedure that can be used with payers in prior approval and/or appeals.
- A sample appeal letter for the TULSA-PRO procedure to be used with payers who have issued an initial claims denial.
- An updated list of literature references that can be used to support a request for medical necessity, an appeal letter, and other request for supporting documents.

Please email **reimbursement@profoundmedical.com** for these documents and other supporting materials as well as with any questions or to request a meeting to discuss.

## Limitations

Profound Medical can assist you in obtaining appropriate payment; however, there are legal restrictions that must be followed. Here are some examples what we cannot do:

- Substitute for the patient's health care team of physicians or their staff.
- Advise on appropriate diagnosis codes for individual patients.
- Abbreviate the claim payment timeframe for some payers (however, we can assist you by explaining the review and payment process for a particular payer).
- Advise on pricing or maximizing profits.

It is important to include all costs incurred when submitting claims to payers, as they will use these claims directly to establish appropriate payment rates in future years.

All codes and modifiers listed in this document represent possible coding options. It is always the provider's responsibility to determine and submit appropriate codes, modifiers, and charges for rendered services. Since many payers may have their own specific coding requirements, it is advisable for providers to obtain written coding verification from payers before filing any claims.

# MEDICARE GENERAL GUIDANCE

## HCPCS C-Code

Medicare Hospital Outpatient Department (HOPD) and Ambulatory Surgical Center (ASC) facility claims should include C1889 (Implantable / insertable device, not otherwise classified) to report the TULSA-PRO procedure.

While there is no payment associated with C1889, Medicare requires that the cost for all devices used during a procedure be reported. It is important to include all costs incurred when submitting claims to Medicare, as Medicare will use these claims directly to establish appropriate payment rates in future years.

C-codes only pertain to the facility portion of a procedure.

## Medicare Administrative Contractor (MAC)

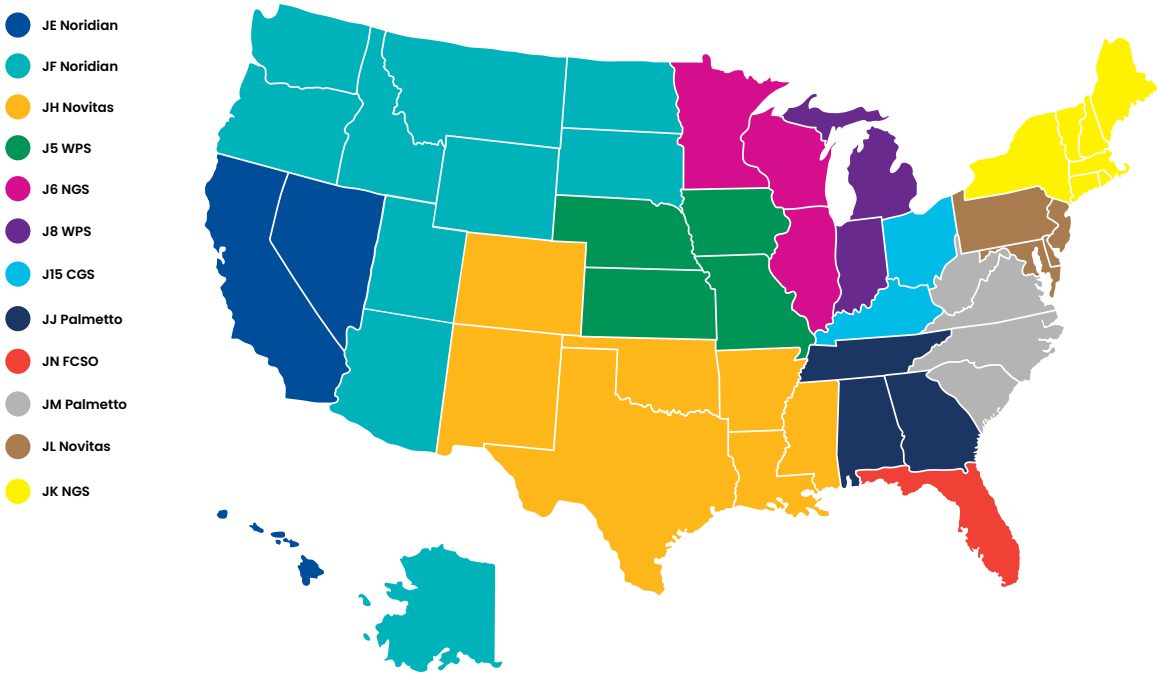
The US is divided into twelve (12) regions for the purposes of administering Medicare claims, including local coverage determinations. MACs are private health care insurers that have been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims for Medicare Fee-For-Service (FFS) beneficiaries.

In the absence of a national Medicare policy, each MAC decides separately, according to its own criteria, whether to cover a procedure and, if so, under what circumstances. Typically, if a procedure is a CPT Category I code, as the TULSA-PRO procedure codes are for 2025, it is covered in all Medicare Jurisdictions.

It is possible that different MACs will issue different local coverage determinations (LCDs) or that CMS will issue a national coverage determination (NCD).

If a procedure is covered, the payment amount assigned by CMS to the CPT codes in the fee schedule are adjusted based on geographic wage indices.

As of this report, there have been no regional or national determinations of coverage. If the provider reasonably anticipates that Medicare may not cover the TULSA-PRO service, the provider must give notice to the Medicare beneficiary before the service is provided through an Advanced Beneficiary Notification (ABN) in order to collect payment from the patient).



# MEDICARE GENERAL GUIDANCE

## Advance Beneficiary Notice of Noncoverage (ABN)

An ABN is a written notice issued to a Fee-For-Service (FFS) Medicare beneficiary – before the provider furnishes items or services – when the provider has reason to believe that Medicare may not cover (and thus, pay for) an item or service. There are various reasons for the provider to expect that Medicare may not cover items or services, including that it deems the procedure investigational or experimental or not medically necessary. To be valid, the ABN must be issued prior to the beneficiary receiving the service. The form must include a good faith estimate of the fees the beneficiary would pay.

The ABN allows the beneficiary to make an informed decision about whether to receive the item or service that may not be covered and to accept financial responsibility if Medicare does not pay. If the ABN is not provided to the beneficiary prior to the service, the beneficiary may not be held financially liable if Medicare denies payment.

An ABN should be completed if the provider reasonably anticipates that Medicare may not cover the TULSA-PRO service.

Commercial or private payers may have a similar form in effect. Check your payer contracts on how the ABN concept may apply to specific commercial or private plans.

## Establishing Medical Necessity

Because Medicare and some private payers formulate coverage restrictions on devices and procedures, facility and physician claims may be denied if the claims do not adequately document the medical necessity for the TULSA-PRO procedure. Therefore, it is critical for providers to submit all appropriate documentation of medical necessity for TULSA-PRO procedure claims to avoid unnecessary payment delays or denials. Profound Medical has sample letters of medical necessity that a facility and physician may use as models to include with initial claim submissions that is available upon request. Please contact reimbursement@profoundmedical.com for the materials.

## NOTES

# PRIVATE AND COMMERCIAL INSURANCE GENERAL GUIDANCE

Private or commercial insurers often will follow Medicare guidelines or use Medicare as a benchmark in developing policies. However, private insurers are able to, and often will, devise their own coverage policies. Therefore, expect to encounter great variance in billing and coverage practices and procedures among private payers.

## Medicare Advantage

Medicare Advantage plans are private insurance plans that cover all Medicare services, and most offer extra coverage than Original Medicare. These plans must follow rules set by Medicare, which should mean that the TULSA-PRO Category I CPT codes are covered for Medicare Advantage Plans specifically. However, physicians should confirm with the Medicare Advantage plan their coverage and reporting guidelines for the TULSA-PRO procedure.

## Prior Authorization

Precertification, preauthorization, prior authorization, utilization management – most physician offices and health care providers are familiar with these terms. They generally have the same application: it is the process by which insurers evaluate medical necessity and the appropriateness and efficient use of health care services. Insurers use these processes to manage costs. It may involve extra effort on the part of the physician and patient to provide the necessary forms and documentation to the insurer. Insurers often have their own guidelines and policies for obtaining prior authorization, such as their own forms, background information, and documentation requirements.

Especially for new procedures that may not yet be familiar to insurers, such as TULSA-PRO, obtaining prior authorization provides a mechanism to begin dialog with payers on how to report the procedure, what coverage guidelines may be relevant, and appropriate payment levels. In most cases, payers may only require this process for the first few claims until they have been able to establish standard processes for adjudicating these claims.

It is important to always check with each specific insurance plan to know what information they require. That said, nearly all payers will require the following documentation:

- Past history of the health issue (including the conditions surrounding its original manifestation)
- Physical documentation such as lab results and images (PSA tests, prostate biopsy results, MRIs and other imaging tests, symptom scores, etc.)
- Supporting information that solidifies the medical necessity for the service and why the treatment is appropriate
- Any treatments that have already been tried and their duration

Insurers use the prior authorization process to validate medical necessity. Payers often have established medical necessity criteria for various treatments and services. Profound Medical has sample letters of medical necessity and prior authorization that maybe of assistance to a facility and physician as models to include with initial claim submissions that is available upon request. Please contact reimbursement@profoundmedical.com for the materials.

Profound Medical does not recommend the use of any specific diagnosis and/or procedure codes for a particular patient. The patient's medical status and the medical record must support all diagnoses and procedures reported on a claim form. Only a physician is qualified to make the diagnosis and treatment decisions documented in the patient's medical record.

# HOSPITAL OUTPATIENT BILLING AND CODING

| HOPD Payment (Facility) | | | | |
|---|---|---|---|---|
| | | | | 2025 Medicare Ntl. Avg. Physician Payment |
| Code | Indicators OPPS \| ASC | OPPS APC | APC Description | HOPD |
| 55882 | J1 \| | 5377 | Level 7 Urology and Related Services | $12,992 |
| C1889 | No payment but required to be reported on claim to capture device costs | | | |

| Physician Payment Option 1: One Physician | | |
|---|---|---|
| | | 2025 Medicare Ntl. Avg. Physician Payment |
| Code | Description | Facility |
| 55882 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed | $579 |

| Physician Payment Option 1: Two Physicians | | |
|---|---|---|
| | | 2025 Medicare Ntl. Avg. Physician Payment |
| Code | Description | Facility |
| 55881 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation | $471 |
| 51721 | Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed | $209 |

When submitting a bill in the outpatient setting:
- Always indicate a revenue code for each device and each service performed
- Always indicate a CPT®/HCPCS code for each device and each service performed

## Diagnosis

There are many different ICD-10-CM diagnosis codes that could be appropriate, depending on the patient's condition. Common diagnosis codes representative of the TULSA-PRO procedure are:

C61 Malignant neoplasm of prostate
N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms
N40.3 Nodular prostate with lower urinary tract symptoms
R97.21 Rising PSA following treatment for malignant neoplasm of prostate

## Procedure

Effective January 1, 2025, there is one CPT® Category I code for facility reporting:

55882 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed

CPT® code 55882 is assigned to APC 5377, Level 7 Urology and Related Services and has a status indicator of J1, Comprehensive APC (C-APC). This means that payment for all covered Part B services on the claim are packaged with the primary J1 service for the claim, except the Comprehensive APC payment policy exclusions.

55882 is currently classified as a device-intensive procedure, which means that a significant portion of the procedure's cost is related to a device – in this case, the TULSA-PRO procedure. Outpatient facilities must report a device code for TULSA-PRO when reporting 55882 to support the device-intensive nature of the procedure. Because there is currently no specific device code for the TULSA-PRO procedure, the most appropriate device code is:

C1889 Implantable / insertable device, not otherwise classified

Report C1889 for a miscellaneous device that is implanted or inserted during an OPPS procedure that is not described by a specific HCPCS C-code. Reporting this code with 55882 satisfies the OPPS edit requiring a device code to be reported on a claim when a device is used.

CPT® codes 51721 (Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed) and 55881 (Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation) are not paid in the HOPD.

# HOSPITAL OUTPATIENT BILLING AND CODING

## Revenue Codes

When submitting a bill in the outpatient setting, indicate a revenue code for each device and each service performed. Hospital billing staff should confirm the appropriate revenue codes to use at their facility because the revenue code on the bill should reflect the cost center where the procedure costs are reported on the hospital's cost report. An important consideration is to use an appropriate revenue code that captures devices to ensure it applies toward device-intensity. The following revenue code may be appropriate for reporting the TULSA-PRO procedure:

0278 Medical/Surgical Supplies and Devices – Other Implants

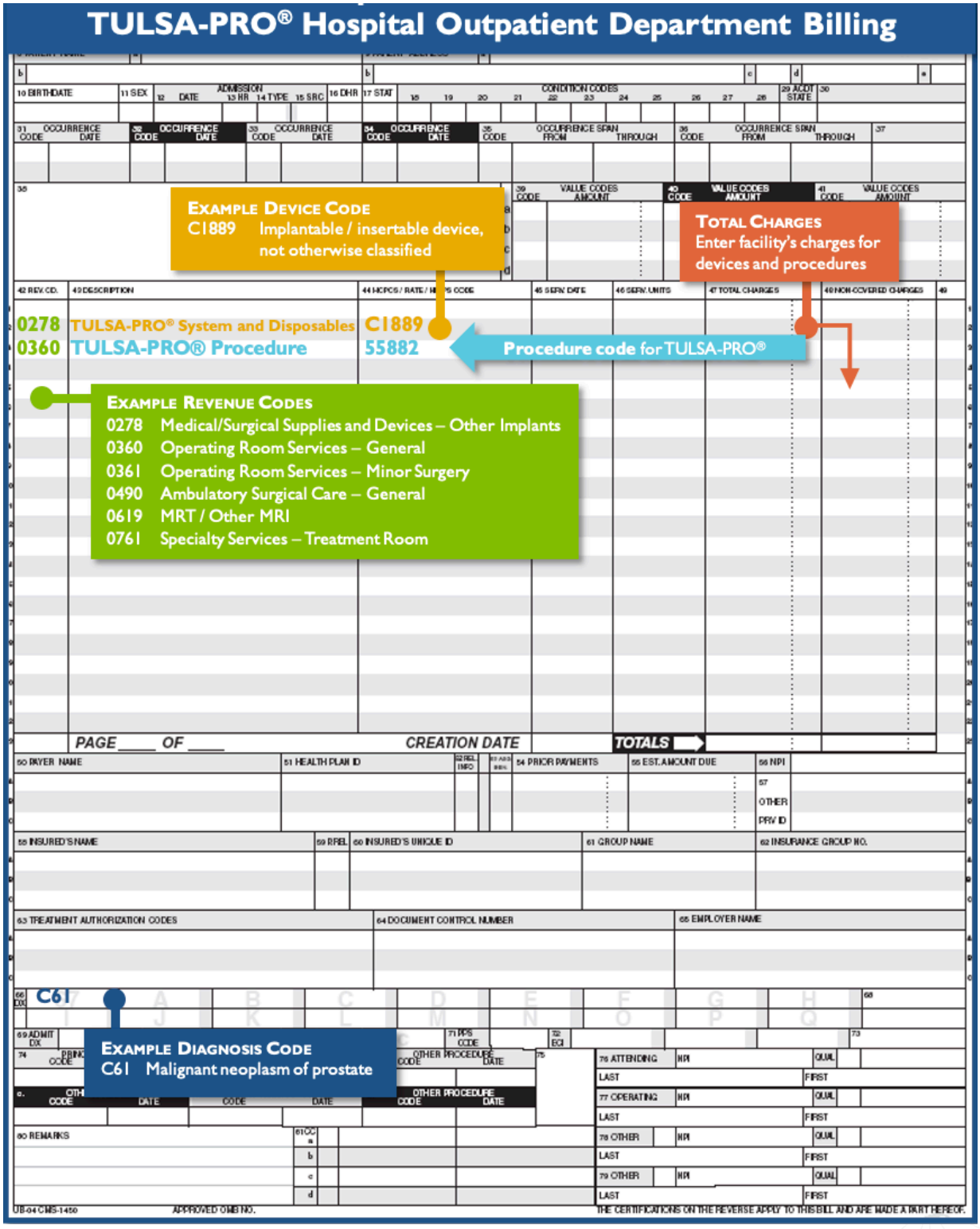
## Private Insurance

Some payers may require prior authorization before the physician treats the patient. Payers often have established medical necessity criteria for various treatments and certain diagnostic tests. Please contact Profound Medical at reimbursement@profoundmedical.com for the types of information and materials you may wish to include in the prior authorization request.

You also will need to confirm if a private payer requires reporting HCPCS C-code C1889.

## NOTES

# SAMPLE UB-04 CLAIM FORM



# AMBULATORY SURGICAL CENTER (ASC) BILLING AND CODING

| ASC Payment (Facility) | | | | |
|---|---|---|---|---|
| Code | Indicators ASC | ASC APC | APC Description | 2025 Medicare Ntl. Avg. Physician Payment HOPD |
| 55882 | J8 | 5377 | Level 7 Urology and Related Services | $10,728 |
| C1889 | No payment but required to be reported on claim to capture device costs | | | |

| Physician Payment Option 1: One Physician | | |
|---|---|---|
| Code | Description | 2025 Medicare Ntl. Avg. Physician Payment Facility |
| 55882 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed | $579 |

| Physician Payment Option 1: Two Physicians | | |
|---|---|---|
| Code | Description | 2025 Medicare Ntl. Avg. Physician Payment Facility |
| 55881 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation | $471 |
| 51721 | Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed | $209 |

When submitting a bill in the ASC setting:
- Always indicate a revenue code for each device and each service performed
- Always indicate a CPT®/HCPCS code for each device and each service performed

## Diagnosis

There are many different ICD-10-CM diagnosis codes that could be appropriate, depending on the patient's condition. Common diagnosis codes representative of the TULSA-PRO procedure are:

C61 Malignant neoplasm of prostate
N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms
N40.3 Nodular prostate with lower urinary tract symptoms
R97.21 Rising PSA following treatment for malignant neoplasm of prostate

## Procedure

Effective January 1, 2025, there is one CPT® Category I code for facility (ASC) reporting:

55882 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed

55882 is currently classified as a device-intensive procedure, which means that ASC payment takes into account that a significant portion of the procedure's cost is related to a device – in this case, the TULSA-PRO procedure. ASCs must report a device code for TULSA-PRO when reporting 55882 to continue to support the device-intensive nature of the procedure. Because there is currently no specific device code for the TULSA-PRO procedure, the most appropriate device code is:

C1889 Implantable / insertable device, not otherwise classified

Report C1889 for a miscellaneous device that is implanted or inserted during a procedure that is not described by a specific HCPCS C-code. Reporting this code with 5882 satisfies the claim edit requiring a device code to be reported on a claim when a device is used.

CPT® codes 51721 (Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed) and 55881 (Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation) are not paid in the ASC.

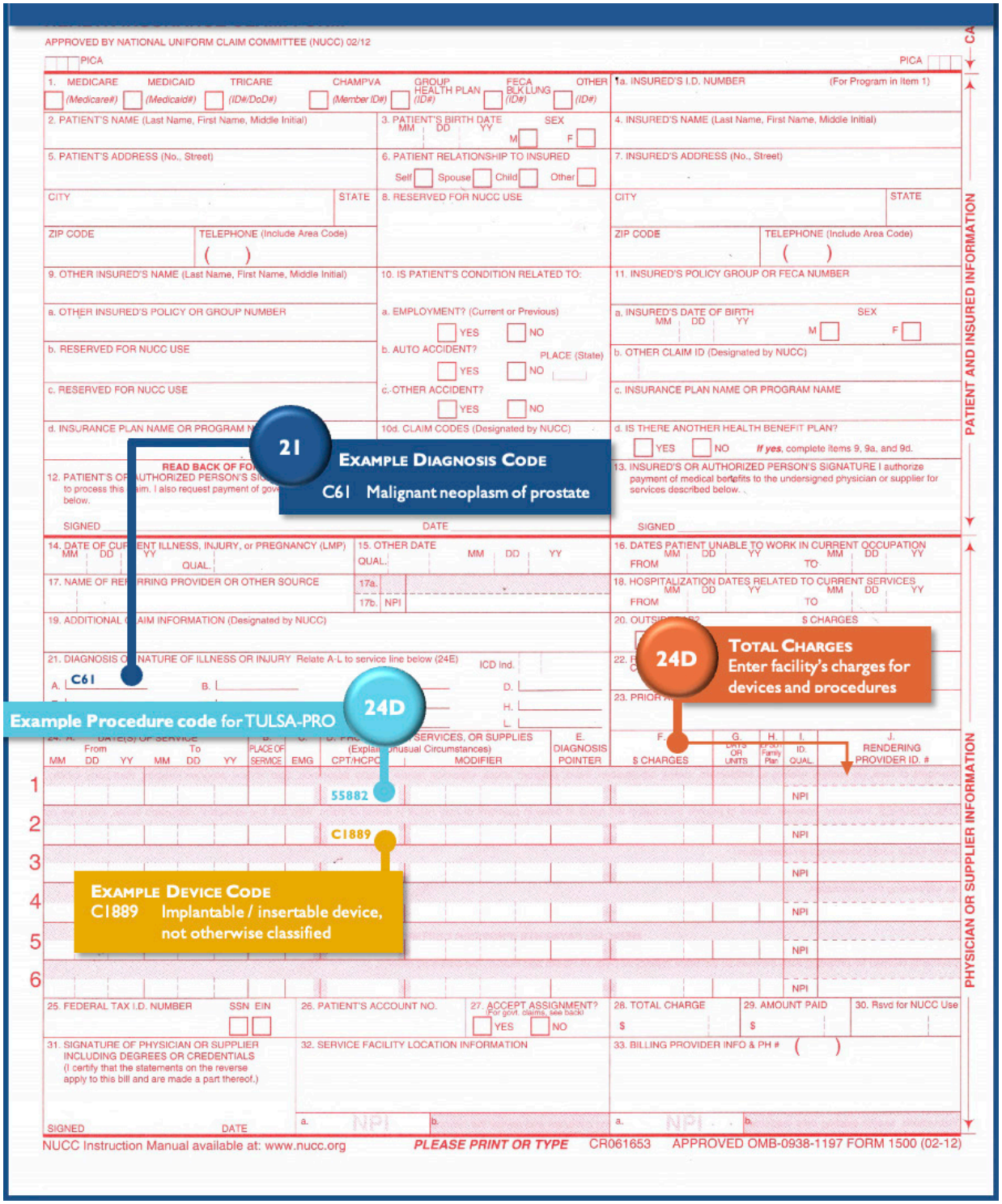
## Private Insurance

Some payers may require prior authorization before the physician treats the patient. Payers often have established medical necessity criteria for various treatments and certain diagnostic tests. Please contact Profound Medical at reimbursement@profoundmedical.com for the types of information and materials you may wish to include in the prior authorization request.

You also will need to confirm if a private payer requires reporting HCPCS C-code C1889.

You also will need to confirm that a private payer will accept HCPCS C-code C1889.

# SAMPLE CMS1500 CLAIM FORM FOR ASC BILLING



# PHYSICIAN SERVICES BILLING & CODING IN THE FACILITY

| 2025 Relative Value Units (RVU) and Time | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Code | Global | Work RVUs | NF PE RVUs | Fac PE RVUs | MP RVUs | Total NF RVUs | Total Fac RVUs | Intra-Svc Time | Total Time |
| 51721 | 000 | 4.05 | 11.70 | 1.92 | 0.50 | 16.25 | 6.47 | 29 mins | 82 mins |
| 55881 | 000 | 9.80 | 252.08 | 3.59 | 1.17 | 263.05 | 14.56 | 120 mins | 202 mins |
| 55882 | 000 | 11.50 | 259.18 | 4.88 | 1.53 | 272.21 | 17.91 | 125 mins | 222 mins |

| Physician Payment Option 1: One Physician | | |
|---|---|---|
| | | 2025 Medicare Ntl. Avg. Physician Payment |
| Code | Description | Facility |
| 55882 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed | $579 |

| Physician Payment Option 1: Two Physicians | | |
|---|---|---|
| | | 2025 Medicare Ntl. Avg. Physician Payment |
| Code | Description | Facility |
| 55881 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation | $471 |
| 51721 | Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed | $209 |

## Facility (OPPS/ASC) Billing

All three codes that report the TULSA-PRO procedure are to be used to report the physician work regardless of the site-of-service. The TULSA-PRO procedure codes have different RVUs and physician reimbursement amounts depending on the site-of-service. Please refer to the tables at the beginning of this section for the specific RVUs and dollar amounts for each procedure.

It is important that the provider indicate the correct site-of-service on the claim form. The correct indicator for the OPPS setting is either "19" for an off-site outpatient hospital or "24" for an on-site outpatient hospital and the correct indicator for the ASC setting is "22".

## Diagnosis

There are many different ICD-10-CM diagnosis codes that could be appropriate, depending on the patient's condition. Common diagnosis codes representative of the TULSA-PRO procedure are:

C61 Malignant neoplasm of prostate
N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms
N40.3 Nodular prostate with lower urinary tract symptoms
R97.21 Rising PSA following treatment for malignant neoplasm of prostate

Some payers may require prior authorization before the physician treats the patient. Payers often have established medical necessity criteria for various treatments and certain diagnostic tests. Please contact Profound Medical at reimbursement@profoundmedical.com for the types of information and materials you may wish to include in the prior authorization request.

If the procedure is performed in the office place of service, the provider will receive a payment amount that includes the cost of the device, as well as all equipment, supplies, clinical labor, and indirect expenses such as rent, insurance, taxes, etc.

This means the total RVUs and reimbursement when performed in this site-of-service are much greater than when performed in a facility (Outpatient Hospital or ASC).

## Procedure

The CPT codes for the TULSA-PRO procedure are used to code the physician's work regardless of the site-of-service. However, the RVUs and reimbursement amounts vary between a facility site-of-service and a non-facility site-of-service such as the office. Please reference the tables at the beginning of this section for the specific RVU and reimbursement amounts.

If one physician performs the entire procedure, that physician should bill CPT Code 55882 (see below for full descriptor).

If the procedure is performed by two physicians, the physician performing the device management (e.g., transducer insertion) should report CPT code 51721 (see below for full descriptor, and the physician performing the ablation should report 55881 (see below for full descriptor).

CPT® codes to report the TULSA-PRO procedure include:

51721 Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed

# PHYSICIAN SERVICES BILLING & CODING IN THE FACILITY

55881 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation

55882 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed

Anesthesiologists should bill separately for their anesthesia services.

## Global Period

All three codes that report the TULSA-PRO procedure have a 000-day global, so there is a zero-day post-operative period. This means that all services related to the procedure are considered to be performed on the day of the procedure itself, with no additional follow-up visits included in the payment for the surgery. Thus, any additional or follow-up visits would reported with an appropriate established patient Evaluation and Management visit code. (e.g. CPT code 99213, 99214, 99215)

## Modifiers

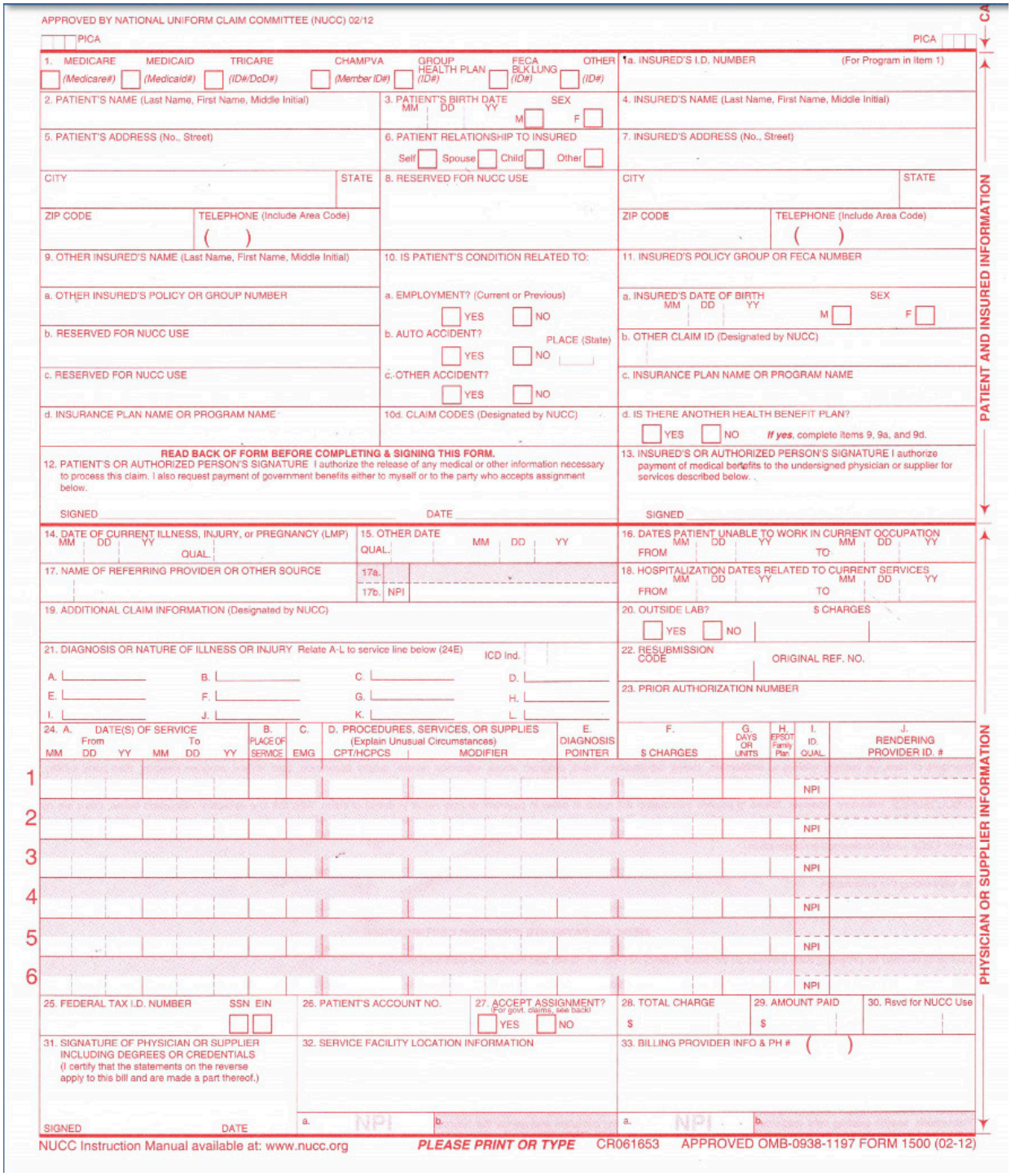
CPT® modifiers are two-character codes that add more information to the CPT® code. Modifiers do not change the CPT® code, but they call attention to special circumstances associated with the service or procedure that the patient received.

Please refer to the usage columns in the table below for more information on when specific modifiers are appropriate. For example, modifier 22 may be applicable for the codes for the TULSA-PRO procedure when the procedure time (either intra-service or total time) significantly exceeds the times listed in the page 3 table "2025 Relative Value Units (RVUs) and Time" or the procedure is deemed significantly more difficult.

Modifiers are justified by medical records and other medical documentation. They should not be used unless facts support their use. Policies for modifier usage may be payer-dependent and contract-dependent. The following chart identifies some of the modifiers that may be used with TULSA-PRO codes when appropriate and needed:

| Modifier | Description | Usage |
|---|---|---|
| 22 | Increased Procedural Services | Append to a surgical procedure when the physician's work required to perform the procedure is more than is typically needed. |
| 47 | Anesthesia by Surgeon | Append to a procedure when the surgeon who performs the procedure also administers the regional or general anesthesia. |
| 52 | Reduced Services | Append to a procedure to show that the physician did not perform the complete procedure in the code descriptor. |
| 53 | Discontinued Procedure | Append to a surgical procedure when the physician begins a procedure and then decides to terminate it, since continuing the procedure will threaten the patient's health. |
| 76 | Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional | Append to a procedure or service that the same provider repeats after performing the initial procedure. |
| 77 | Repeat Procedure by Another Physician or Other Qualified Health Care Professional | Append to a procedure or service that a different provider repeats after another provider performed the initial procedure. |
| 99 | Multiple Modifiers | Append to a procedure or service as the first modifier when there are also two or more additional modifiers applicable to the service or procedure. |
| AQ | Physician providing a service in an unlisted health professional shortage area (HPSA) | Append to represent the services that the provider renders in zip code areas that fall within a listed health professional shortage area, or HPSA. |
| GA | Waiver of liability statement issued as required by payer policy, Individual case | Append to a code when a payer requires the provider to present an advance beneficiary notice, or ABN, before the patient receives an item or service the provider expects Medicare not to cover. |
| GZ | Item or service expected to be denied as not reasonable and necessary | Append when the provider expects a Medicare denial for an item or service as not a medical necessity but does not provide the patient with an advance beneficiary notice, or ABN. |
| XE | Separate encounter, a service that is distinct because it occurred during a separate encounter | Append to services that the provider performs for a patient at separate encounters on the same date of service. |
| XS | Separate structure, a service that is distinct because it was performed on a separate organ/structure | Append to a service that the provider performs for a patient on a separate organ or structure. |
| XU | Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service | Append to a service that is distinct because it does not overlap with the usual components of the main service. |

# SAMPLE CMS1500 CLAIM FORM FOR PHYSICIAN BILLING



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | NPI | |
| 2 | | | | | | | | | | NPI | |
| 3 | | | | | | | | | | NPI | |
| 4 | | | | | | | | | | NPI | |
| 5 | | | | | | | | | | NPI | |
| 6 | | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CA

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

# PHYSICIAN SERVICES BILLING & CODING IN THE NON-FACILITY (OFFICE/OFFICE-BASED-LAB) SETTING

| 2025 Relative Value Units (RVU) and Time | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Code | Global | Work RVUs | NF PE RVUs | Fac PE RVUs | MP RVUs | Total NF RVUs | Total Fac RVUs | Intra-Svc Time | Total Time |
| 51721 | 000 | 4.05 | 11.70 | 1.92 | 0.50 | 16.25 | 6.47 | 29 mins | 82 mins |
| 55881 | 000 | 9.80 | 252.08 | 3.59 | 1.17 | 263.05 | 14.56 | 120 mins | 202 mins |
| 55882 | 000 | 11.50 | 259.18 | 4.88 | 1.53 | 272.21 | 17.91 | 125 mins | 222 mins |

| Physician Payment Option 1: One Physician | | |
|---|---|---|
| | | 2025 Medicare Ntl. Avg. Physician Payment |
| Code | Description | Facility |
| 55882 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed | $579 |

| Physician Payment Option 1: Two Physicians | | |
|---|---|---|
| | | 2025 Medicare Ntl. Avg. Physician Payment |
| Code | Description | Facility |
| 55881 | Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation | $471 |
| 51721 | Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed | $209 |

## Facility (OPPS/ASC) Billing

All three codes that report the TULSA-PRO procedure are to be used to report the physician's work regardless of the site-of-service. The TULSA-PRO procedure codes have different RVUs and physician reimbursement amounts depending on the site-of-service. Please refer to the tables at the beginning of this section for the specific RVUs and dollar amounts for each procedure.

It is important that the provider indicates the correct site-of-service on the claim form. The correct indicator for the Office/Office-Based Lab (OBL) setting is "11".

## Diagnosis

There are many different ICD-10-CM diagnosis codes that could be appropriate, depending on the patient's condition. Common diagnosis codes representative of the TULSA-PRO procedure are:

C61 Malignant neoplasm of prostate
N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms
N40.3 Nodular prostate with lower urinary tract symptoms
R97.21 Rising PSA following treatment for malignant neoplasm of prostate

Some payers may require prior authorization before the physician treats the patient. Payers often have established medical necessity criteria for various treatments and certain diagnostic tests. Please contact Profound Medical at reimbursement@profoundmedical.com for the types of information and materials you may wish to include in the prior authorization request.

If the procedure is performed in the office place of service, the provider will receive a payment amount that includes the cost of the device, as well as all equipment, supplies, clinical labor, and indirect expenses such as rent, insurance, taxes, etc.

This means the total RVUs and reimbursement when performed in this site-of-service are much greater than when performed in a facility (Outpatient Hospital or ASC).

## Procedure

The CPT codes for the TULSA-PRO procedure are used to code the physician's work regardless of the site-of-service. However, the RVUs and reimbursement amounts vary between a facility site-of-service and a non-facility site-of-service such as the office. Please reference the tables at the beginning of this section for the specific RVU and reimbursement amounts.

If one physician performs the entire procedure, that physician should bill CPT Code 55882 (see below for full descriptor).

If the procedure is performed by two physicians, the physician performing the device management (e.g., transducer insertion) should report CPT code 51721 (see below for full descriptor, and the physician performing the ablation should report 55881 (see below for full descriptor).

CPT® codes to report the TULSA-PRO procedure include:

51721 Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed

# PHYSICIAN SERVICES BILLING & CODING IN THE NON-FACILITY (OFFICE/OFFICE-BASED-LAB) SETTING

55881 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation

55882 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed

Anesthesiologists should bill separately for their anesthesia services.

## Global Period

Unlike the majority of other prostate intervention procedures, all three codes that report the TULSA-PRO procedure have a 000-day global, so there is a zero-day post-operative period.

This means that all services related to the procedure are considered to be performed on the day of the procedure itself, with no additional follow-up visits included in the payment for the surgery. Thus, any additional or follow-up visits would reported with an appropriate established patient Evaluation and Management visit code. (e.g. CPT code 99213, 99214, 99215)

## Modifiers

CPT® modifiers are two-character codes that add more information to the CPT® code. Modifiers do not change the CPT® code, but they call attention to special circumstances associated with the service or procedure that the patient received.

Please refer to the usage columns in the table below for more information on when specific modifiers are appropriate. For example, modifier 22 may be applicable for the codes for the TULSA-PRO procedure when the procedure time (either intra-service or total time) significantly exceeds the times listed in the page 3 table "2025 Relative Value Units (RVUS) and Time" or the procedure is deemed significantly more difficult.

Modifiers are justified by medical records and other medical documentation. They should not be used unless facts support their use. Policies for modifier usage may be payer-dependent and contract-dependent. The following chart identifies some of the modifiers that may be used with TULSA-PRO codes when appropriate and needed:

| Modifier | Description | Usage |
|---|---|---|
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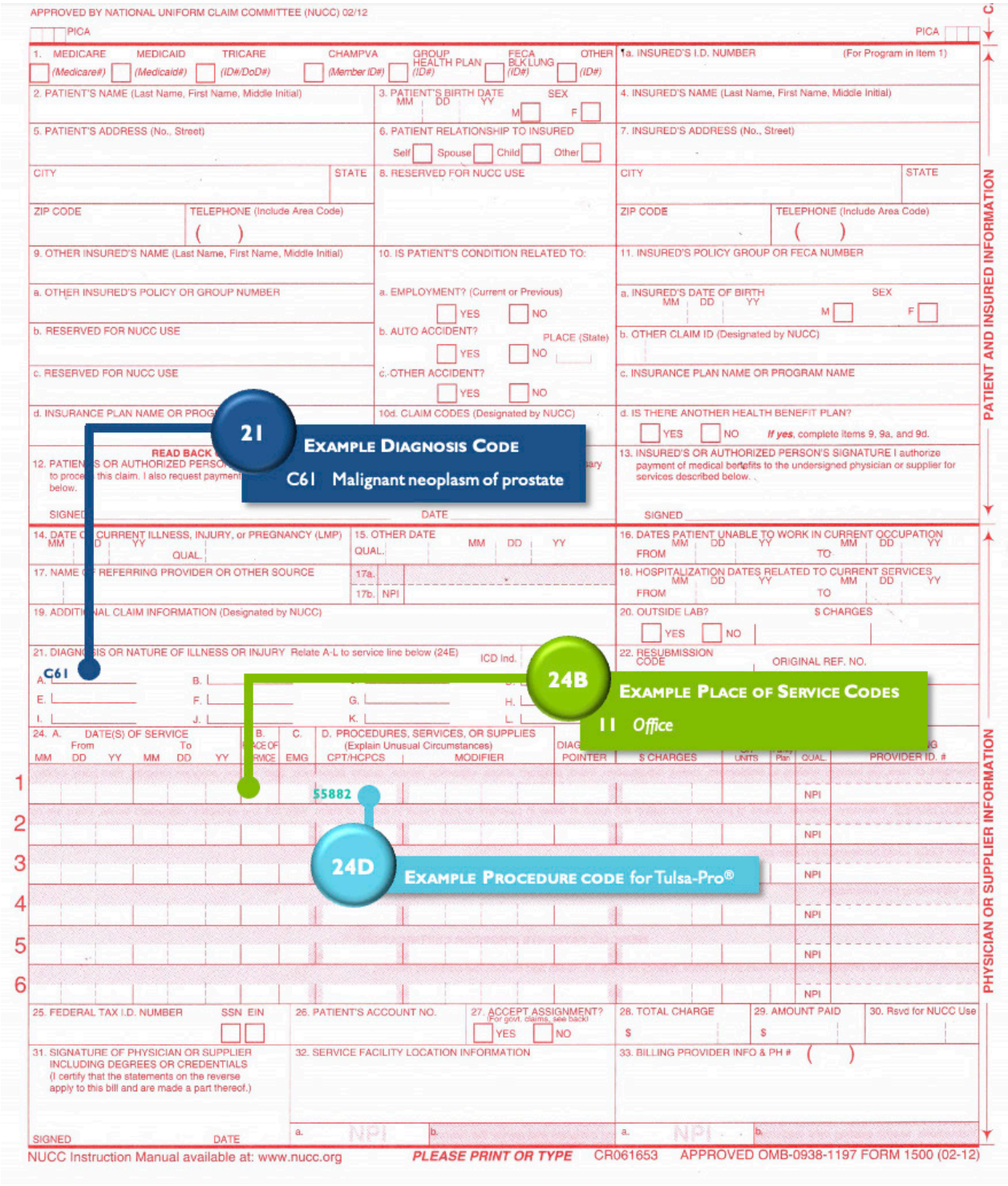
| 52 | Reduced Services | Append to a procedure to show that the physician did not perform the complete procedure in the code descriptor. |
| 53 | Discontinued Procedure | Append to a surgical procedure when the physician begins a procedure and then decides to terminate it, since continuing the procedure will threaten the patient's health. |
| 76 | Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional | Append to a procedure or service that the same provider repeats after performing the initial procedure. |
| 77 | Repeat Procedure by Another Physician or Other Qualified Health Care Professional | Append to a procedure or service that a different provider repeats after another provider performed the initial procedure. |
| 99 | Multiple Modifiers | Append to a procedure or service as the first modifier when there are also two or more additional modifiers applicable to the service or procedure. |
| AQ | Physician providing a service in an unlisted health professional shortage area (HPSA) | Append to represent the services that the provider renders in zip code areas that fall within a listed health professional shortage area, or HPSA. |
| GA | Waiver of liability statement issued as required by payer policy, Individual case | Append to a code when a payer requires the provider to present an advance beneficiary notice, or ABN, before the patient receives an item or service the provider expects Medicare not to cover. |
| GZ | Item or service expected to be denied as not reasonable and necessary | Append when the provider expects a Medicare denial for an item or service as not a medical necessity but does not provide the patient with an advance beneficiary notice, or ABN. |
| XE | Separate encounter, a service that is distinct because it occurred during a separate encounter | Append to services that the provider performs for a patient at separate encounters on the same date of service. |
| XS | Separate structure, a service that is distinct because it was performed on a separate organ/structure | Append to a service that the provider performs for a patient on a separate organ or structure. |
| XU | Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service | Append to a service that is distinct because it does not overlap with the usual components of the main service. |

# SAMPLE CMS1500 CLAIM FORM FOR PHYSICIAN BILLING IN NON-FACILITY SETTING (OFFICE/OFFICE-BASED LAB)



# ADDITIONAL MRI SERVICES CODES

In addition to the new codes describing the TULSA-PRO procedure, there are also new CPT codes to describe physician and clinical staff work done for MRI services when the patient has a previous inserted implant or foreign body that requires additional assessment, preparation, and effort.

The following new codes address medical physics services provided during MR exams and procedures. If a TULSA-PRO patient requires these services, the provider should use them to the extent applicable.

- **CPT code 76014:** MR safety assessment by trained clinical staff, including identification and verification of implant or foreign body components through surgical reports, imaging, or device databases. This includes analysis of the MR conditional status and professional consultation, with a written report for the initial 15 minutes of service.
- **CPT code +76015:** Add-on code to 76014 for each additional 30 minutes of MR safety assessment, with a written report.
- **CPT code 76016:** MR safety determination by a physician or qualified health professional, involving a review of implant MR conditions, risk-benefit analysis, and necessary equipment planning, with a written report.
- **CPT code 76017:** Custom MR safety planning and monitoring by a medical physicist or MR safety expert, including tailoring MR acquisition requirements for implants and risk mitigation for non-conditional implants or foreign bodies. A written report with physician review is included.
- **CPT code 76018:** MR safety preparation for implant electronics, such as programming pulse generators or transmitters to reduce risks during MR procedures, under physician supervision, with a written report.
- **CPT code 76019:** MR safety positioning and/or immobilization of implants under physician supervision to prevent forces or burns caused by the MR environment, with a written report.

## NOTES

# FILING INITIAL CLAIMS

Because Medicare and some private payers formulate coverage restrictions on devices and procedures, facility and physician claims may be denied if the claims do not adequately document the medical necessity for the TULSA-PRO procedure. It is critical for providers to submit all appropriate documentation of medical necessity for initial TULSA-PRO procedure claims to avoid unnecessary payment delays or rejections.

To expedite the processing of denied claims that may result when payers deny a claim due to lack of medical necessity, please contact Profound Medical at reimbursement@profoundmedical.com for the types of information and materials you may wish to include in the prior authorization request.

You also will need to confirm if a private payer requires reporting HCPCS C-code C1889.

In addition, review the checklist for claim submissions and appeals for tips in preparing and submitting TULSA-PRO procedure claims.

## Checklist for Claim Submission and Appeal

- If necessary, obtain prior authorization from the insurer prior to the procedure
- Verify which codes to use with the patient's insurer
- Submit appropriate documentation
- Include a description of the TULSA-PRO System
- Include a letter of medical necessity that outlines the patient's medical history and the rationale for the procedure
- Verify the patient's correct name and identification number on the claim form
- Use standard terminology
- Use correct ICD-10-CM diagnosis codes
- Use the correct CPT® codes and any modifiers where and when appropriate
- Apply appropriate revenue codes
- File the claim in a timely fashion

# FREQUENTLY ASKED QUESTIONS

**Q: What is the coding status for physician services?**

A: Effective January 1, 2025, there are three CPT® Category I codes to report the TULSA-PRO procedure, depending on if one or two physicians are performing the service. These replace the unlisted codes, 55899 and 53899, that would have been used in 2024 to report physician services for the TULSA-PRO procedure.

- 51721 Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed
- 55881 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation
- 55882 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed

If one physician performs the entire procedure, that physician should bill 55882.

If the procedure is performed by two physicians, the physician performing the transducer insertion should report 51721, and the physician performing the ablation should report 55881.

**Q: What is the coding status for facility reporting?**

A: Effective January 1, 2025, there is one CPT® Category I codes for facility reporting:

- 55882 Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed

Additionally, facilities should report HCPCS C-code C1889, Implantable/insertable device, not otherwise classified. Verify with commercial payers regarding this requirement to report C-codes.

55882 replaces C9734 for facility billing of the TULSA-PRO procedure. C9734 should no longer be used for TULSA-PRO procedures.

**Q: What is a C-code?**

A: C-codes are unique temporary pricing codes established by CMS that apply only to the hospital outpatient facility and the ambulatory surgery center (ASC) settings. They do not apply to physician services. Medicare requires their use on facility claims when services include a medical device, such as TULSA-PRO, even if there is no additional payment associated with the C-code. This is because Medicare incorporates the charges submitted with the C-code when it reviews ratesetting.

**Q: Is the C-code used to report physician services?**

A: No. C1889 is only for the facility's services.

**Q: What happened to C9734 to report TULSA-PRO?**

A: C9734 no longer applies to the TULSA-PRO procedure as of December 31, 2024, because of the new CPT® Category I codes for the TULSA-PRO procedure effective January 1, 2025.

Both facilities and physicians will now use the new CPT® Category I codes-55882 for facilities and 51721 /55881 or 55882 for the PFS.

**Q: Can I bill Medicare patients for the full cost of the TULSA-PRO procedure?**

A: The patient is responsible for coinsurance and any deductible; however, the provider cannot balance bill a Medicare patient (that is, bill the patient the difference between the amount charged and the amount Medicare allows). If an ABN is in place and Medicare does not cover the TULSA-PRO procedure, the provider may bill the patient the amount specified in the ABN.

If an ABN is in place and Medicare does cover the service, the provider may only bill the patient the amount allowed by Medicare (as specified on the Remittance Advice Notice). If the provider collected payment from the patient in advance of the procedure, the provider must refund excess funds as appropriate to the patient. Providers who enter into contracts with commercial insurers typically have similar processes and policies.

**Q: Why do facilities need to report a device code C1889 with 55882?**

A: Medicare expects facilities to submit accurate and complete charges on claims, including complying with policy that devices are reported with procedures that require use of the device. Because there currently is no specific device code for the TULSA-PRO procedure, the most appropriate device code to report with 55882 is C1889, Implantable / insertable device for device intensive procedure, not otherwise classified.

**Q: Should physicians report a device code when using the TULSA-PRO when billing for their services?**

A: No. Only facilities are required to report device codes.

**Q: How should I bill for anesthesia if I perform TULSA-PRO procedure in the office setting?**

A: CPT® guidelines instruct that supplies and materials such as drugs, tray supplies, and materials that are usually provided with anesthesia services are considered incidental to the anesthesia service codes (00100 – 01999) and should not be reported separately.

Supplies and materials provided over and above those usually included may be reported separately. Therefore, certain additional agents used by anesthesia providers, such as Propofol, can be reported and paid separately in addition to the anesthesia service. Local anesthesia drugs, such as Lidocaine, should not be reported separately.

Policies may be payer-dependent and contract-dependent. For example, there are instances where practices have contracted with payers for a flat rate, which includes the costs of drugs and supplies plus the anesthesia service.

Profound Medical Inc. 2400 Skymark Ave. Unit #6 Mississauga, ON L4W 5K5, Canada



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