TULSA-PRO®

2026 Coding and Billing Guide

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. 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 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. 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.

REIMBURSEMENT SUPPORT

Documentation

Insurance carriers, including Medicare, review submitted claims for the procedure to determine the appropriateness of medical necessity. Emerging technologies and procedures can require additional documentation for coverage and patient-specific adjudication. Profound Medical can provide additional resources upon request such as:

- Sample letter of medical necessity for prior authorization and/or appeals
- Sample appeal letter for denials
- Literature references to support a request for medical necessity or appeal

Limitations

There are legal restrictions that must be followed. This is not a fully exhaustive list. Below are examples of what cannot be done:

- Substitute for the patient's health care team of physicians or their staff
- Advise on appropriate diagnosis codes for individual patients
- Advise on pricing
- Abbreviate the claim payment timeframe for some payers

For TULSA-PRO Reimbursement Support, please contact:
reimbursement@profoundmedical.com

To learn more about TULSA-PRO Prior Authorization Support Program, please contact:
tulsaproauth@profoundmedical.com
Phone: 1-855-378-7027
Fax: 1-855-379-1441

CONTENTS

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 details.

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
N40.2	Nodular prostate without lower urinary tract symptoms
N40.3	Nodular prostate with lower urinary tract symptoms
R97.21	Rising PSA following treatment for malignant neoplasm of prostate

2026 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	3.95	12.47	1.31	0.49	16.91	5.75	29 mins	82 mins
55881	000	9.56	266.97	2.06	1.24	277.77	12.86	120 mins	202 mins
55882	000	11.21	275.96	3.01	1.58	288.75	15.80	125 mins	222 mins

Physician Payment Option 1: One Physician

Code	Description	2026 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. 0-Day Global Code	$9,684	$528

Physician Payment Option 1: Two Physicians

Code	Description	2026 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. 0-Day Global Code	$9,317	$430
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. 0-Day Global Code	$567	$192

HOPD and ASC Payment (Facility)

Code	Indicators HOPD | ASC		HOPD APC	APC Description	2026 Medicare Ntl. Avg. Physician Payment	
					HOPD	ASC
55882	J1	J8	5377	Level 7 Urology and Related Services	$13,479	$10,874
C1889	Required to be reported on claim to capture device costs					

- The non-Qualifying Participant Conversion factor to calculated payment was $33.40
- 51721 and 55881 do not have HOPD or ASC facility payment
- 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]
- Physician, HOPD, and ASC payment levels reflect Medicare national average payment levels in effect as of January 1, 2026. Medicare payments are adjusted geographically and by quality payment reporting

CODING / BILLING THE TULSA-PRO PROCEDURE

MEDICARE

Common ICD-10-CM Diagnosis Code

Common ICD-10-CM Diagnosis Code	
C61	Malignant neoplasm of prostate
N40.1	Benign prostatic hyperplasia with lower urinary tract symptoms
N40.2	Nodular prostate without lower urinary tract symptoms
N40.3	Nodular prostate with lower urinary tract symptoms
R97.21	Rising PSA following treatment for malignant neoplasm of prostate

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 payer contracts on how the ABN concept may apply to specific commercial or private plans.

MEDICARE HCPCS C-CODE GUIDANCE

HCPCS C1889

Medicare Hospital Outpatient Department (HOPD) and Surgical Center (ASC) facility claims should include C1889 (insertable device, not otherwise classified) to report procedure. Costs should be included when submitting claims to Medicare.

- There is **no payment associated with C1889**. Medicare requires that the cost for implantable/ insertable devices used during a procedure be reported
- C-codes only pertain to facility coding

Medical Necessity Documentation

Providers should submit all appropriate documentation of medical necessity for TULSA-PRO procedure. 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.

PRIVATE AND COMMERCIAL INSURANCE

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, there may be 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. 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 is the process by which insurers evaluate medical necessity and the appropriateness and efficient use of health care services. The physician and patient will need to provide the necessary forms and documentation to the insurer to gain an authorization for the procedure.

New procedures may require obtaining prior authorization. Payers may only require this process for claims until there is an established standard process for adjudicating claims.

Most payers require the following documentation for prior authorization:

- 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

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

To learn more about TULSA-PRO Prior Authorization Support Program, please contact:

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HOSPITAL OUTPATIENT (HOPD) & ASC

HOPD Payment (Facility)					
Code	HOPD or ASC Indicators	HOPD or ASC APC	APC Description	2026 Medicare Ntl. Avg. Physician Payment	
				HOPD	ASC
55882	J1	5377	Level 7 Urology and Related Services	$13,479	$10,728
C1889	Required to be reported on claim to capture device costs				

Physician Payment Option 1: Complete Procedure with One Physician		
Code	Description	2026 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. 0-Day Global Code	$528

Physician Payment Option 2: Two Physicians		
Code	Description	2026 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. 0-Day Global Code	$430
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. 0-Day Global Code	$192

- CPT® code 55882 is used for HOPD or ASC facility payment

When submitting a bill in the HOPD or ASC setting:

- Indicate a revenue code for each device and each service performed
- Indicate a CPT/HCPCS code for each device and each service performed

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.

Reimbursement information is provided for educational purposes only and does not guarantee coverage or payment. Providers are responsible for all coding, billing, and reimbursement decisions.

PROCEDURAL CHARGES FOR FACILITY

Category	CPT/HCPCS Code	Description	Revenue Code	Comments
Primary Procedure	55882	Ablation of prostate tissue, transurethral, using thermal ultrasound, including MRI guidance and monitoring of tissue ablation; with insertion of transurethral ultrasound transducers, including suprapubic tube and endorectal cooling device, when performed.	360	Use when a single physician performs both imaging and ablation. Procedure may be done with 2 physicians. Radiologist (51721) and Urologist (55881) to help report against different departmental revenue codes.
Catheter Supplies	C1889	Implantable/other medical device, category not otherwise classified.	278	Used for TULSA-PRO disposable kit until device-specific HCPCS assigned.
Contrast	Q9950	Injection, Gadoteridol (ProHance) / mL	250	For MR contrast used during procedure.
Anesthesia	1999	Unlisted anesthesia service.	370	Used if no specific anesthesia code applies; document duration & complexity.

Category	CPT/HCPCS Code	Description	Revenue Code	Comments
Primary Procedure (Two Physicians - Urologist)	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.	510	Used when urologist performs device placement portion of TULSA-PRO.
Primary Procedure (Two Physicians - Radiologist)	55881	Ablation of prostate tissue, transurethral, using thermal ultrasound, including MRI guidance for and monitoring of tissue ablation; one component of a two-physician procedure (typically radiologist).	360	Used when the radiologist performs MRI guidance, ablation, and monitoring portion of TULSA-PRO.

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 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.

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.

PHYSICIAN SERVICES (IN-FACILITY)

2026 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
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0-Day Global Code Physician Payment Option 2: Two Physicians		
		2026 Medicare Ntl. Avg. Physician Payment
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- The non-Qualifying Participant Conversion factor to calculated payment was $33.40

Physician Billing in Facility (HOPD/ASC)

- TULSA-PRO procedure codes report the physician work regardless of the site-of service
- 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
- Indicate the site-of service on the claim form
    - HOPD setting for Outpatient hospital is 19
    - On-site outpatient hospital is 24
    - ASC setting is 22
    - Office/Office-Based Lab setting is 11

PHYSICIAN SERVICES (OFFICE/OFFICE-BASED LAB)

2026 Relative Value Units (RVU) and Time									
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Physician Payment Option 2: Two Physicians		
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- The non-Qualifying Participant Conversion factor to calculated payment was $33.40

The correct indicator for the Office/Office-Based Lab (OBL) setting is "11". See sample claim form on page 17.

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.

Reimbursement information is provided for educational purposes only and does not guarantee coverage or payment. Providers are responsible for all coding, billing, and reimbursement decisions.

OTHER CONSIDERATIONS

0-Day Global

What's included for a 0-Day Global vs. 90-Day Global

	0-Day Global	90-Day Global
Day of Procedure: - Patient education and consenting - Operative time - Time in recovery & discharge	✓	✓
All Post-Operative Office Visits in first 90 Days Post-op		✓
All Post-Operative routine Imaging in first 90 Days Post-op		✓
Other services in first 90-Day Post-op: - Telehealth visits - Additional imaging - Coordination of care - Transfer of care		✓

0-Day Global Procedures:

Required follow up patient care, future imaging, E&M are separately billable the following day after TulsaPRO.

Simplified Billing & Administration: Because the entire service is bundled, providers only need to submit one claim, reducing the administrative load.

Reduced Administrative Costs: Streamlining documentation for a single day of service reduces the time and resources spent on processing.

Enhanced Cost Transparency: Patients benefit from clearer, bundled pricing, which reduces confusion and unexpected bills.

Additional MRI Service Codes

Additional MRI Service Codes	
CPT Code	Description
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.
+76015	Add-on code to 76014 for each additional 30 minutes of MR safety assessment, with a written report.
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.
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.
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.
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.

MRI is not billed separately as performed in TULSA-PRO procedure.

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.

CLINICAL DOCUMENTATION

Patient Documentation for Prostate Cancer

- 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 for medical necessity and why the treatment is appropriate
    - List of co-morbidities or contraindications to prostatectomy: rheumatic diseases, and musculoskeletal conditions (collectively termed arthritis); hypertension; stomach, intestinal, and gastrointestinal (GI) diseases (GI diseases); urinary conditions; heart disease; cancer (other than prostate); lung disease; diabetes; kidney disease; stroke and neurologic conditions; and blood diseases. *This list is not inclusive.*
- Any treatments that have already been tried along with duration

Patient Documentation for BPH

Essentials for Approval

1. Diagnosis must match FDA indication for TULSA-PRO
   The TULSA-PRO system is indicated for transurethral ultrasound ablation (TULSA) of prostate tissue.
2. Imaging reports, office notes, and current labs (last 6 months), including PSA test results, must be included.
3. Notes of previously tried and failed therapies such as medications and prior surgical interventions.

Practical Clinical Considerations for Treatment with TULSA-PRO

COMMON BPH CRITERIA FOR HEALTH PLAN COVERAGE:

- ☐ Diagnosis of lower urinary tract symptoms (LUTS) secondary to BPH that interfere with activities of daily living: **and**
- ☐ Peak urine flow rate (Qmax) less than 15 cc/sec on a voided volume that is greater than 125 cc; **and**
- ☐ Failed a trial of satisfactory voiding with medication or intolerance to medication (alpha blocker and/or 5-alpha-reductase inhibitor).

COMMON CRITERIA FOR TREATMENT OF URINARY OUTLET OBSTRUCTION DUE TO PROSTATE CANCER:

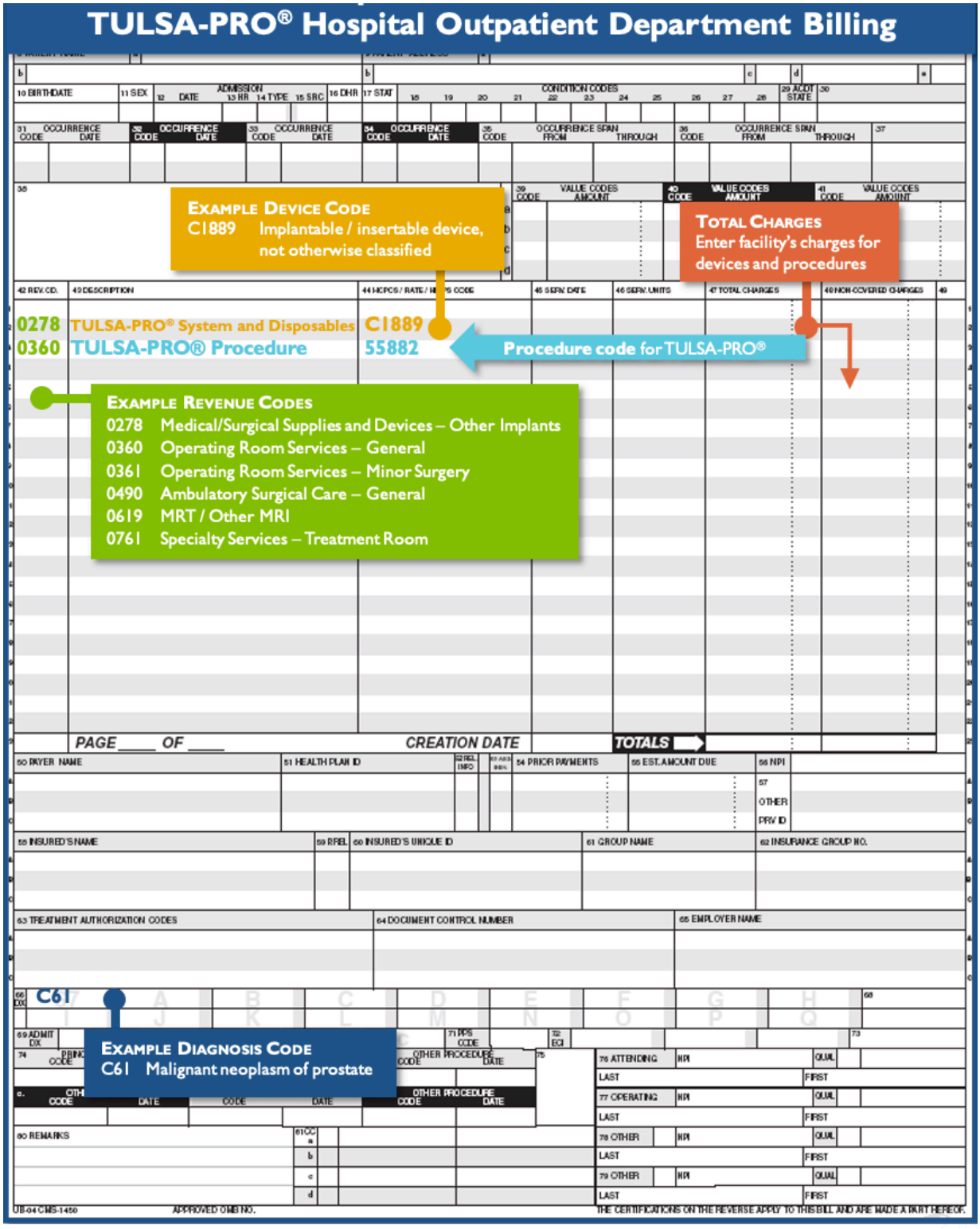
- ☐ Diagnosis or history of prostate cancer and is not a candidate for surgical resection of the prostate, but will be treated by radiation therapy and has symptoms that are so severe that immediate relief is required; **or**
- ☐ Diagnosis or history of prostate cancer and is clinically in remission as evidenced by a prostate specific antigen (PSA) less than 1.0 ng/mL.

FILING CLAIMS

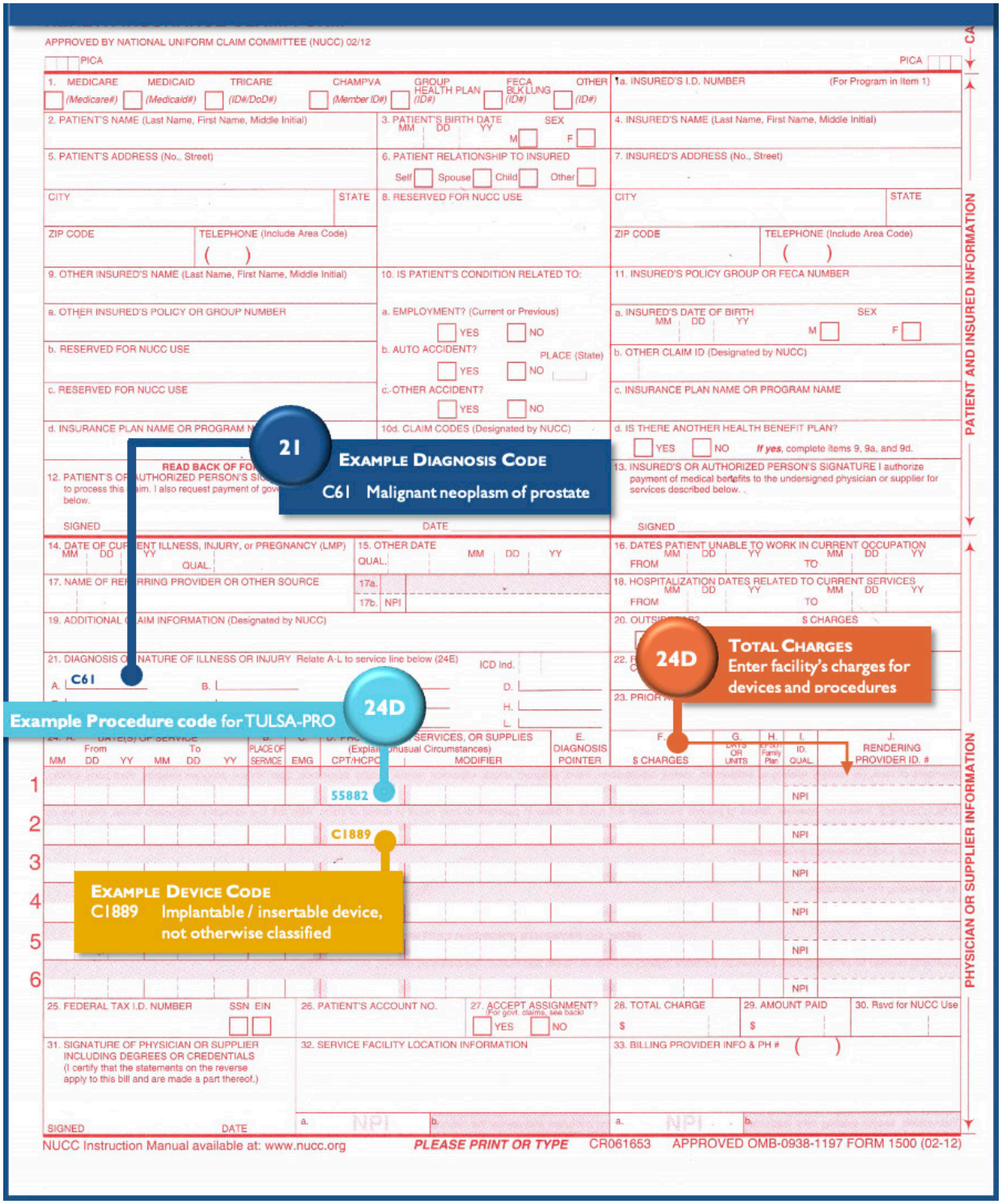
Claims Submission Checklist

- ☐ Obtain prior authorization from the insurer prior to the procedure (if necessary)
- ☐ Verify which codes to use with the patient's insurer
- ☐ Submit appropriate documentation
- ☐ Description of the TULSA-PRO System
- ☐ Letter of medical necessity outlining the patient's medical history and procedure rationale
- ☐ Verity the patient's correct name and identification number on the claim form
- ☐ Use standard terminology; Use correct ICD-10-CM diagnosis codes; correct CPT codes
- ☐ Apply appropriate revenue code. If private payer, confirm requirement to report C-code C1889

SAMPLE UB-04 CLAIM FORM (HOSPITAL OUTPATIENT)

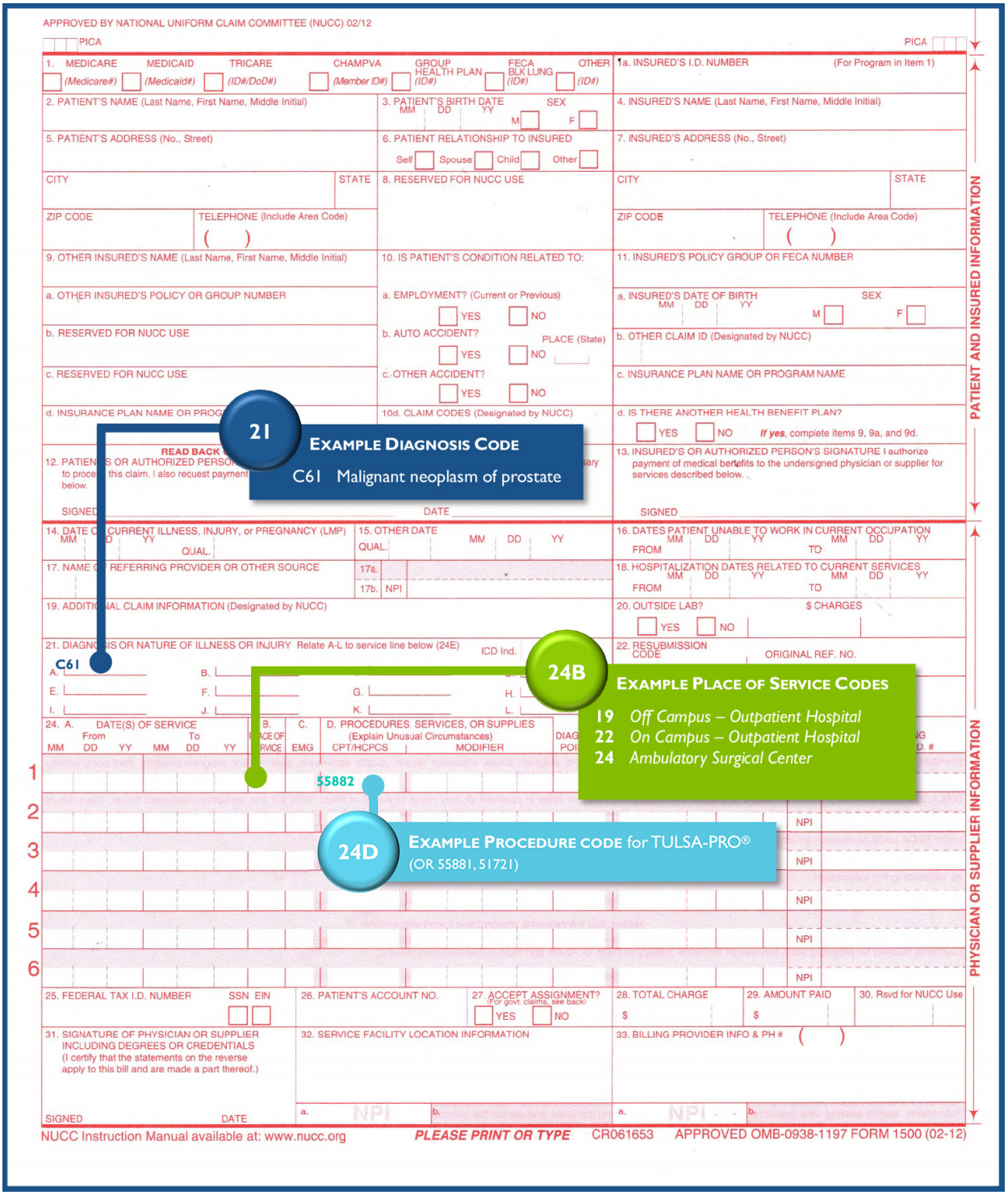


SAMPLE CMS 1500 CLAIM FORM (ASC)



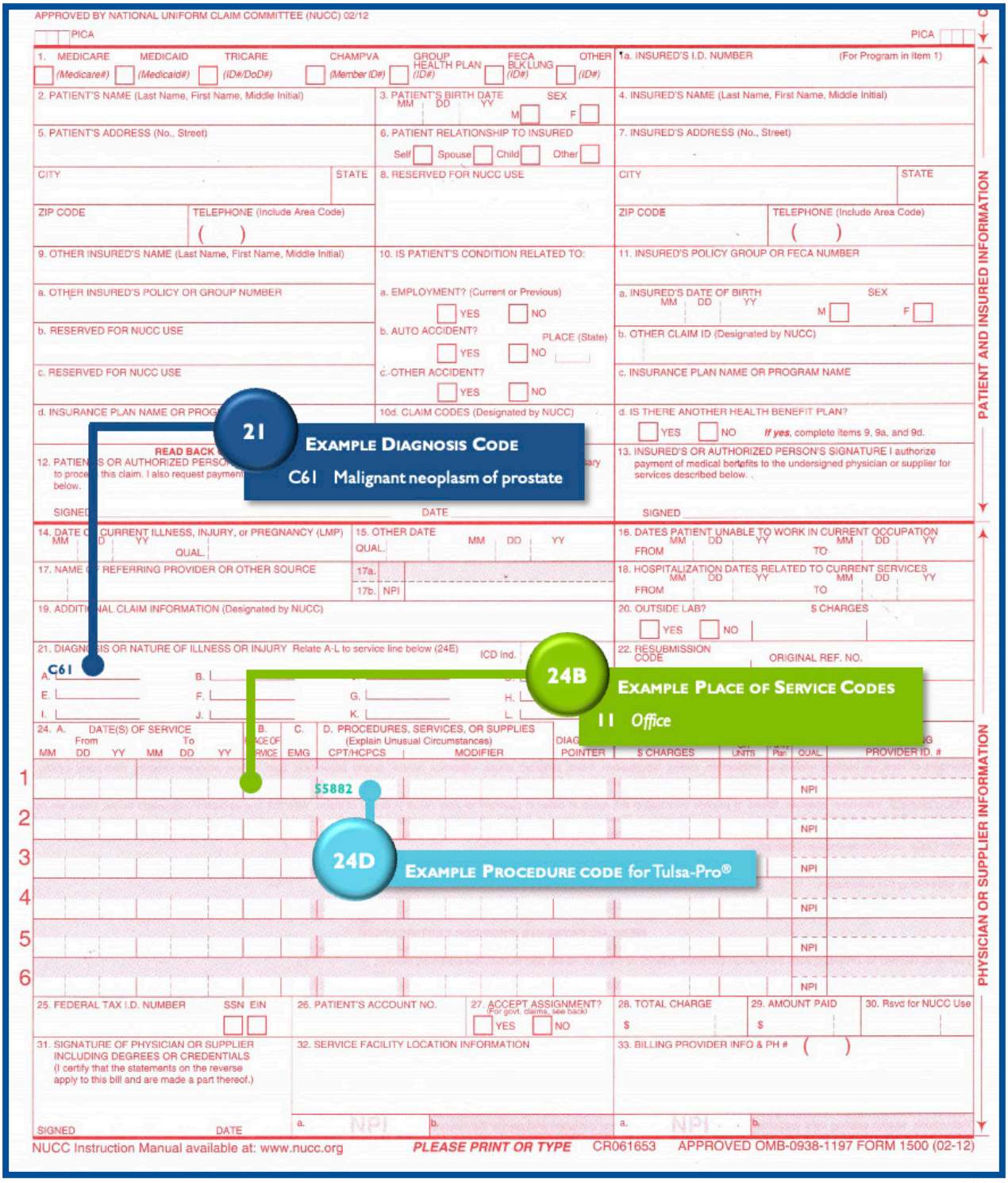
SAMPLE CMS 1500 CLAIM FORM

FOR PHYSICIAN BILLING



SAMPLE CMS 1500 CLAIM FORM

PHYSICIAN BILLING OFFICE/OFFICE-BASED LAB (NON-FACILITY)



FREQUENTLY ASKED QUESTIONS

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 (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 rate setting.

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

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

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.

REIMBURSEMENT DISCLAIMER

This information is provided for general educational purposes only and is not intended to constitute legal, billing, coding, or reimbursement advice. Coverage, coding, and payment policies vary by payer and are subject to change without notice. Providers are responsible for determining appropriate patient selection, coding, documentation, and billing practices, as well as for confirming coverage and payment with the applicable payer prior to submitting claims.

Nothing in this guide should be construed as a guarantee of coverage or reimbursement, or as influencing clinical decision-making. Clinical decisions should be based solely on the independent medical judgment of the healthcare provider and the individual needs of the patient.

The manufacturer does not recommend or encourage billing for services that are not medically necessary, appropriately documented, or consistent with applicable laws, regulations, and payer requirements. Providers should consult their own reimbursement specialists, legal counsel, or payer representatives for guidance specific to their practice.

For TULSA-PRO Reimbursement Support, please contact:
reimbursement@profoundmedical.com

To learn more about TULSA-PRO Prior Authorization Support Program, please contact:
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