aScope 4 Cysto &
aScope 5 Cysto HD

2025 Cystoscopy Coding and Reimbursement Guide

aScope™ Cysto Portfolio

Ambu

Exploring aScope 4 Cysto & aScope 5 Cysto HD

The Ambu® aScope 4 Cysto is a single-use, sterile, flexible cystoscope that offers an intuitive, lightweight design with similar functionality to reusable cystoscopes. The aScope 4 Cysto is compatible with the aView™ 2 Advanced HD monitor and provides a portable solution equipped with clear and sharp imaging, smooth maneuverability and consistent quality that is always available.

The single-use aScope 5 Cysto HD builds on the features of aScope 4 Cysto but includes additional features such as advanced imaging capabilities via ARC image enhancement and broader compatibility with accessories (e.g. lasers and high-frequency tools).

Product Specifications & Indications for Use:

- aScope 4 Cysto
- aScope 5 Cysto HD

For clinical and economic information on aScope 4 Cysto and aScope 5 Cysto HD, please visit our product page: Supporting Evidence - aScope 4 Cysto

Hospital Outpatient, Ambulatory Surgical Center, and Physician Office Coding and Payment: National

The table below provides an overview of potential billing and coding with associated Medicare national payment rates when aScope 4 Cysto or aScope Cysto HD are used in hospital outpatient departments (HOPDs; places of service 19 and 22), ambulatory surgical centers (ASCs; place of service 24), and physician offices (place of service 11).

CPT Codes and 2025 Medicare National Payment Rates for Cystourethroscopy Procedures

CPT® Code[1]	CPT Descriptor	Physician Payment[2]		Facility Payment[3]		
		Non-Facility	Facility	APC	HOPD	ASC
52000	Cystourethroscopy (separate procedure)	$213.16	$77.31	5372	$667.47	$315.93
52001	With irrigation and evacuation of multiple obstructing clots	$407.24	$275.27	5374	$3,448.97	$1,655.31
52005	With ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	$275.27	$128.74	5373	$2,048.51	$959.88
52007	With ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis	$411.77	$160.44	5374	$3,448.97	$1,655.31
52010	With ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service	$349.99	$159.79	5372	$667.47	$315.93
52204	With biopsy	$343.20	$136.18	5373	$2,048.51	$959.88
52214	With fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	$686.07	$168.20	5374	$3,448.97	$1,655.31
52224	With fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	$718.09	$194.40	5374	$3,448.97	$1,655.31
52234	With fulguration (including cryosurgery or laser surgery) and/or resection of SMALL bladder tumor(s)	n/a	$236.13	5374	$3,448.97	$1,655.31
52235	With fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s)	n/a	$276.56	5374	$3,448.97	$1,655.31
52240	With fulguration (including cryosurgery or laser surgery) and/or resection of LARGE bladder tumor(s)	n/a	$375.22	5375	$5,083.62	$2,521.60
52250	With insertion of radioactive substance, with or without biopsy or fulguration	n/a	$229.98	5374	$3,448.97	$1,655.31
52260	With dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	n/a	$202.49	5373	$2,048.51	$959.88
52265	With dilation of bladder for interstitial cystitis; local anesthesia	$338.34	$156.56	5373	$2,048.51	$230.31
52270	Cystourethroscopy, with internal urethrotomy; female	$385.57	$175.32	5373	$2,048.51	$959.88
52275	With internal urethrotomy; male	$498.46	$239.04	5373	$2,048.51	$959.88
52276	With direct vision internal urethrotomy	n/a	$253.92	5373	$2,048.51	$959.88
52277	With resection of external sphincter (sphincterotomy)	n/a	$309.88	5374	$3,448.97	$1,655.31

Continued

CPT Codes and 2025 Medicare National Payment Rates for Cystourethroscopy Procedures

CPT® Code[1]	CPT Descriptor	Physician Payment[2]		Facility Payment[3]		
		Non-Facility	Facility	APC	HOPD	ASC
52281	With calibration and/or dilation of urethral stricture or tenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	$296.94	$146.85	5373	$2,048.51	$959.88
52282	With insertion of permanent urethral stent	n/a	$323.47	5374	$3,448.97	$1,655.31
52283	With steroid injection into stricture	$326.05	$194.73	5373	$2,048.51	$959.88
52285	For treatment of female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, fulguration of polyp(s) of urethra, bladder neck, and/or trigone	$322.17	$189.87	5372	$667.47	$315.93
52287	With injection(s) for chemodenervation of the bladder (NOTE: See relevant HCPCS code on page 5).	$354.84	$163.03	5373	$2,048.51	$959.88
52290	With ureteral meatotomy, unilateral or bilateral	n/a	$234.19	5373	$2,048.51	$959.88
52300	With resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	n/a	$268.48	5374	$3,448.97	$1,655.31
52301	With resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	n/a	$278.18	5374	$3,448.97	$1,655.31
52305	With incision or resection of orifice of bladder diverticulum, single or multiple	n/a	$266.54	5375	$5,083.62	$2,521.60
52310	With removal of foreign body, calculus, ureteral stent from urethra or bladder (separate procedure); simple	$292.41	$146.21	5373	$2,048.51	$959.88
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	$437.00	$263.30	5373	$2,048.51	$959.88
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	$821.28	$332.52	5374	$3,448.97	$1,655.31
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	n/a	$453.50	5374	$3,448.97	$1,655.31
52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	n/a	$236.78	5374	$3,448.97	$1,655.31
52325	(Including ureteral catheterization); with fragmentation of ureteral calculus (e.g., ultrasonic or electrohydraulic technique)	n/a	$306.64	5375	$5,083.62	$2,521.60
52327	(Including ureteral catheterization); with subureteric injection of implant material	n/a	$248.10	5375	$5,083.62	$3,564.37
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	$558.62	$252.63	5374	$3,448.97	$1,655.31
52332	With insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)	$362.60	$150.09	5374	$3,448.97	$1,655.31
52334	With insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	n/a	$176.61	5374	$3,448.97	$1,655.31

Physician Relative Value Units (RVUs)

2025 Physician Relative Value Units (RVUs)[4]

Conversion Factor: $32.3465

CPT Code	CPT Descriptor	Non-Facility	Facility
52000	Cystourethroscopy (separate procedure)	6.59	2.39
52001	With irrigation and evacuation of multiple obstructing clots	12.59	8.51
52005	With ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service	8.51	3.98
52007	With ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with brush biopsy of ureter and/or renal pelvis	12.73	4.96
52010	With ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service	10.82	4.94
52204	With biopsy	10.61	4.21
52214	With fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	21.21	5.2
52224	With fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	22.2	6.01
52234	With fulguration (including cryosurgery or laser surgery) and/or resection of SMALL bladder tumor(s)	n/a	7.3
52235	With fulguration (including cryosurgery or laser surgery) and/or resection of MEDIUM bladder tumor(s)	n/a	8.55
52240	With fulguration (including cryosurgery or laser surgery) and/or resection of LARGE bladder tumor(s)	n/a	11.6
52250	With insertion of radioactive substance, with or without biopsy or fulguration	n/a	7.11
52260	With dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	n/a	6.26
52265	With dilation of bladder for interstitial cystitis; local anesthesia	10.46	4.84
52270	With internal urethrotomy; female	11.92	5.42
52275	With internal urethrotomy; male	15.41	7.39
52276	With direct vision internal urethrotomy	n/a	7.85
52277	With resection of external sphincter (sphincterotomy)	n/a	9.58
52281	With calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	9.18	4.54
52282	With insertion of permanent urethral stent	n/a	10
52283	With steroid injection into stricture	10.08	6.02
52285	For treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone	9.96	5.87
52287	With injection(s) for chemodenervation of the bladder	10.97	5.04
52290	With ureteral meatotomy, unilateral or bilateral	n/a	7.24
52300	With resection or fulguration of orthotopic ureterocele(s), unilateral or bilateral	n/a	8.3

Continued

2025 Physician Relative Value Units (RVUs)[4]

Conversion Factor: $32.3465

CPT Code	CPT Descriptor	Non-Facility	Facility
52301	With resection or fulguration of ectopic ureterocele(s), unilateral or bilateral	n/a	8.6
52305	With incision or resection of orifice of bladder diverticulum, single or multiple	n/a	8.24
52310	With removal of foreign body, calculus, ureteral stent from urethra or bladder (separate procedure); simple	9.04	4.52
52315	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder (separate procedure); complicated	13.51	8.14
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	25.39	10.28
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	NA	14.02
52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	NA	7.32
52325	(Including ureteral catheterization); with fragmentation of ureteral calculus (e.g., ultrasonic or electrohydraulic technique)	n/a	9.48
52327	(Including ureteral catheterization); with subureteric injection of implant material	n/a	7.67
52330	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus	17.27	7.81
52332	With insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)	11.21	4.64
52334	With insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	n/a	5.46

Medicare Hospital Inpatient Coding and MS-DRG Payments: National

Medicare Severity Diagnosis Related Groups (MS-DRGs) are reported for payment in the hospital inpatient (place of service 21), MS-DRG assignment will vary based on the patient's diagnoses and procedure(s) performed during the patient encounter. Below are the most common MS-DRGs for procedures that may involve the aScope 4 Cysto and/or aScope Cysto HD; however, others may apply.

MS-DRG	Descriptor	Payment Rate[5]
656	Kidney and ureter procedures for neoplasm with MCC	$21,166.45
657	Kidney and ureter procedures for neoplasm with CC	$11,877.17
658	Kidney and ureter procedures for neoplasm without CC/MCC	$9,771.38
659	Kidney and ureter procedures for non-neoplasm with MCC	$16,790.48
660	Kidney and ureter procedures for non-neoplasm with CC	$8,705.81
661	Kidney and ureter procedures for non-neoplasm without CC/MCC	$6,670.19
662	Minor bladder procedures with MCC	$20,267.86
663	Minor bladder procedures with CC	$9,923.42
664	Minor bladder procedures without CC/MCC	$7,015.85
668	Transurethral procedures with MCC	$18,946.95
669	Transurethral procedures with CC	$9,765.22
670	Transurethral procedures without CC/MCC	$6,904.00

CC: Comorbid Condition; MCC: Major Comorbid Condition

Hospital Revenue Codes

Revenue codes are used by hospitals to report services and supplies to specific cost centers. The following are potential revenue codes that may be used when billing for the aScope 4 Cysto and/or aScope Cysto HD.

Revenue Code	Descriptor
272	Sterile Supplies
278[6]	Medical/surgical supplies and implants; other implants

References

1. Current Procedural Terminology (CPT) Copyright 2024 American Medical Association
2. Centers for Medicare and Medicaid Services, 2025 Medicare Physician Fee Schedule, available at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched
3. 2025 CMS OPPS/ASC Final Rule, Addendum AA and B. Accessed via: https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda
4. CMS PFS Relative Value Files. Available at: https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files/rvu25a
5. CMS FY 2025 IPPS Final Rule MS-DRG: https://www.federalregister.gov/d/2024-22501

For more information, please email **us-reimbursement@ambu.com**

For a customized cost analysis of reusable vs. single-use endoscopes, contact **us-healthecon@ambu.com**

The reimbursement information provided in this guide was obtained from third-party sources and information that is publicly available on the internet. The reported Medicare national average payments are subject to change and may vary based on geographic location and other individual factors. Information in this guide is not legal advice, or advice about how to code or complete claims for payment. It is the provider's responsibility to report the appropriate codes based on the procedures furnished to a specific patient and the patient's documented medical condition. Providers are responsible for submitting claims for services consistent with the specific payer billing requirements.

Payer billing, coding, and coverage requirements vary from payer to payer and are updated and change over time. Ambu encourages providers to verify current billing, coding and coverage policies and requirements with the specific payer if the provider has questions.

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