Boston Scientific

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Interventional Oncology Radiofrequency Ablation 2024 Billing and Coding Guide

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IMPORTANT INFORMATION:

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex andfrequently changing laws, regulations, rules, and policies. This information is presented for illustrativepurposes only and does not constitute reimbursement or legal advice. Boston Scientific encouragesproviders to submit accurate and appropriate claims for services. **It is always the provider's sole responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered.** It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends thatyou consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters.

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This coding information may include codes for procedures for which Boston Scientific currently offersno cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independentmedical judgment of the HCP.

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RF 3000™ Radiofrequency Ablation System

2024 CODING GUIDES WITH MEDICARE ALLOWABLE REIMBURSEMENT

This product can only be used by licensed healthcare professionals. Caution: Federal lawrestricts this device to sale by or on the order of a physician. Additional important safetyinformation about the above products is available at the following website addresshttps://www.bostonscientific.com/en-US/products/ablation/RF3000-Radiofrequency- Generator.html. Please review if you intend to use this product.

ABOUT RADIOFREQUENCY ABLATION

RF 3000 Radiofrequency Generator, LeVeen and Soloist Needles

- The RF 3000 Generator is intended only for use in conjunction with the LeVeen and Soloist NeedleElectrode Families for the thermal coagulation of soft tissue.
- The LeVeen Needle Electrode Family is intended to be used in conjunction with the RF 3000 Generator for the thermal coagulation necrosis of soft tissues, including partial or complete ablation ofnonresectable liver lesions.
- The Soloist Single Needle Electrode is intended to be used in conjunction with the RF 3000 Generator for the thermal coagulation necrosis of soft tissues, including partial or complete ablation of nonresectable liver lesions.

DEVICE CODING

There are no HCPCS C codes that describe probes used in radiofrequency ablation procedures.

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RADIOFREQUENCY ABLATION - REIMBURSEMENT SUPPORT

We have contracted with The Pinnacle Health Group to assist with coverage and payment activities related to Radiofrequency Ablation treatment, including:

General Reimbursement Support

- Support providers with coding options and tools to reference coding for Radiofrequency Ablation and related procedures.
- Provide current coverage policy information for Radiofrequency Ablation procedures.
- Review inadequate reimbursement or denials.
- Support patient information requests.

Benefit Verification and Prior Authorization Support

- Support providers with prior authorization for Radiofrequency Ablation procedures.
- Support prior authorization requests and appeals.
- Provide appropriate documentation for benefit verification, priorauthorization, and predetermination.

Prior Authorization and Claim Appeals

- Support physicians and patients with the appeal process.
- Assist with appeal letters and documentation necessary to approach payers with appropriate coverage requests.
- Coordinate appeals through permitted appeal steps and peer to peer reviews.
- Follow up with payers regarding requests on a scheduled basis.

The Pinnacle Health Group team is available weekdays from 8:30am to 6:00pm EST (215) 369-9290 or IOAblation@thepinnaclehealthgroup.com

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Liver

Physician, ASC, and Hospital Outpatient Coding and Medicare Allowable (CY 2024)

Service Provided		Physician Fee Schedule[1]			ASC[2]		Hospital Outpatient[3]		
CPT® Code	CPT® Description	RVUs	Non Facility	Facility	Payment	Status Indicator	APC	Status Indicator	Payment
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	14.97	$3,512	$704	$2,706	G2	5361	J1	$5,503
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	20.80	NA	$1,233	NA	NA	5362	J1	$9,818
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	2.00	$97	$97	$0	N1	NA	N	$0
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	3.99	$176	$176	$0	N1	NA	N	$0
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	4.24	$192	$192	$0	N1	NA	N	$0
47000	Biopsy of liver, needle; percutaneous	1.65	$292	$84	$683	A2	5072	J1	$1,546
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), RS&I	0.67	$57	$29	$0	N1	NA	N	$0
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) (Add-on)	0.54	$114	$26	$0	N1	NA	N	$0
77012	Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), RS&I	1.50	$137	$67	$0	N1	NA	N	$0
77021	Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) RS&I	1.50	$418	$68	$0	N1	NA	N	$0
Open Liver Procedure (Medicare "Inpatient Only" Procedures)									
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	24.56	NA	$1,420	NA	NA	NA	C	$0
Unlisted Procedures									
47399	Unlisted procedure, liver	0.00	$0	$0.00	NA	NA	5071	T	$671

The use of modifier 26 indicates that only the professional component of the procedure was provided.

CPT Modifier	Description
-26	Professional Component

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Liver

ICD-10-CM[4] DIAGNOSIS CODES (FY 2024)

The listed ICD-10-CM diagnosis codes are examples of codes that may apply for liver ablation procedures.

Code	ICD-10-CM Description (Diagnosis Codes)
C22.0	Liver cell carcinoma; Hepatocellular carcinoma; Hepatoma
C22.1	Intrahepatic bile duct carcinoma; Cholangiocarcinoma
C22.2	Hepatoblastoma
C22.3	Angiosarcoma of liver; Kupffer cell sarcoma
C22.4	Other sarcomas of liver
C22.7	Other specified carcinomas of liver
C22.8	Malignant neoplasm of liver, primary, unspecified as to type
C22.9	Malignant neoplasm of liver, not specified as primary or secondary
C78.7	Secondary malignant neoplasm of liver and intrahepatic bile duct
C7A.098	Malignant carcinoid tumors of other sites
C7A.1	Malignant poorly differentiated neuroendocrine tumors; High grade neuroendocrine carcinoma, any site
C7A.8	Other malignant neuroendocrine tumors
C7B.02	Secondary carcinoid tumors of liver
C7B.8	Other secondary neuroendocrine tumors
D01.5	Carcinoma in situ of liver, gallbladder and bile ducts
D37.6	Neoplasm of uncertain behavior of liver, gallbladder and bile ducts
D49.0	Neoplasm of unspecified behavior of digestive system
E34.0	Carcinoid syndrome

ICD-10-PCS[5] PROCEDURE CODES (FY 2024)

The listed ICD-10-PCS procedure codes are examples of codes that may apply for liver ablation procedures.

Code	ICD-10-PCS Description (Inpatient Procedure Codes)
0F500ZZ	Destruction of liver, open approach
0F503ZZ	Destruction of liver, percutaneous approach
0F504ZZ	Destruction of liver, percutaneous endoscopic approach
0F510ZZ	Destruction of right lobe liver, open approach
0F513ZZ	Destruction of right lobe liver, percutaneous approach
0F514ZZ	Destruction of right lobe liver, percutaneous endoscopic approach
0F520ZZ	Destruction of left lobe liver, open approach
0F523ZZ	Destruction of left lobe liver, percutaneous approach
0F524ZZ	Destruction of left lobe liver, percutaneous endoscopic approach
0F590ZZ	Destruction of common bile duct, open approach
0F593ZZ	Destruction of common bile duct, percutaneous approach
0F594ZZ	Destruction of common bile duct, percutaneous endoscopic approach

See important notes on the uses and limitations of this information on page 3.

Liver

Medicare Severity-Diagnosis Related Groups (MS-DRGs) [6,7] (FY 2024)

The following MS-DRGs may apply to liver ablation procedures for Medicare patients. Others may apply if additional procedures are performed, along with secondary ICD-10-CM diagnoses, during the same inpatient admission.

Service Provided		Hospital Inpatient	
MS- DRG[8]	MS-DRG Description	GMLoS (Days)	Hospital Payment
356	Other Digestive System O.R. Procedures w/MCC	8	$29,958
357	Other Digestive System O.R. Procedures w/CC	4.4	$15,381
358	Other Digestive System O.R. Procedures w/o CC/MCC	2.5	$8,970
405	Pancreas, Liver & Shunt Procedures W/MCC	9	$38,545
406	Pancreas, Liver & Shunt Procedures W/CC	5	$20,216
407	Pancreas, Liver & Shunt Procedures w/o CC/MCC	3.5	$15,060

See important notes on the uses and limitations of this information on page 3.

Kidney

Physician, ASC, and Hospital Outpatient Coding and Medicare Allowable (CY 2024)

Service Provided		Physician Fee Schedule[1]			ASC[2]		Hospital Outpatient[3]		
CPT® Code	CPT® Description	RVUs	Non Facility	Facility	Payment	Status Indicator	APC	Status Indicator	Payment
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	6.55	$2,703	$329	$2,706	G2	5361	J1	$5,503
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	21.36	NA	$1,130	NA	NA	5362	J1	$9,818
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	2.00	$97	$97	$0	N1	NA	N	$0
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	3.99	$176	$176	$0	N1	NA	N	$0
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	4.24	$192	$192	$0	N1	NA	N	$0
50200	Renal biopsy; percutaneous, by trocar or needle	2.38	$498	$122	$683	A2	5072	J1	$1,546
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	0.67	$57	$29	$0	N1	NA	N	$0
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) (Add-on)	0.54	$114	$26	$0	N1	NA	N	$0
77012	Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation	1.50	$137	$67	$0	N1	NA	N	$0
77021	Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	1.50	$418	$68	$0	N1	NA	N	$0
Unlisted Procedures									
50549	Unlisted laparoscopy procedure, renal	0.00	0	$0	NA	NA	5361	J1	$5,503
53899	Unlisted procedure, urinary system	0.00	0	$0	NA	NA	5371	T	$236

The use of modifier 26 indicates that only the professional component of the procedure was provided.

CPT Modifier	Description
-26	Professional Component

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Kidney

ICD-10-CM[4] DIAGNOSIS CODES (FY 2024)

The listed ICD-10-CM diagnosis codes are examples of codes that may apply for kidney ablation procedures.

Code	ICD-10-CM Description (Diagnosis Codes)
C64.1	Malignant neoplasm of right kidney, except renal pelvis
C64.2	Malignant neoplasm of left kidney, except renal pelvis
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis
C65.1	Malignant neoplasm of right renal pelvis
C65.2	Malignant neoplasm of left renal pelvis
C65.9	Malignant neoplasm of unspecified renal pelvis
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C7A.093	Malignant carcinoid tumor of the kidney
C80.2	Malignant neoplasm associated with transplanted organ

ICD-10-PCS[5] PROCEDURE CODES (FY 2024)

The listed ICD-10-PCS procedure codes are examples of codes that may apply for kidney ablation procedures.

Code	ICD-10-PCS Description (Inpatient Procedure Codes)
0T500ZZ	Destruction of right kidney, open approach
0T503ZZ	Destruction of right kidney, percutaneous approach
0T510ZZ	Destruction of left kidney, open approach
0T513ZZ	Destruction of left kidney, percutaneous approach
0T530ZZ	Destruction of right kidney pelvis, open approach
0T533ZZ	Destruction of right kidney pelvis, percutaneous approach
0T540ZZ	Destruction of left kidney pelvis, open approach
0T543ZZ	Destruction of left kidney pelvis, percutaneous approach
BT41ZZZ	Ultrasonography of right kidney
BT42ZZZ	Ultrasonography of left kidney
BT43ZZZ	Ultrasonography of bilateral kidneys

Medicare Severity-Diagnosis Related Groups (MS-DRGs) [6,7] (FY 2024)

The following MS-DRGs may apply to kidney ablation procedures for Medicare patients. Others may apply if additional procedures are performed, along with secondary ICD-10-CM diagnoses, during the same inpatient admission.

Service Provided		Hospital Inpatient	
MS- DRG[8]	MS-DRG Description	GMLoS (Days)	Hospital Payment
656	Kidney & Ureter Procedures For Neoplasm w/MCC	5.2	$21,968
657	Kidney & Ureter Procedures For Neoplasm w/CC	2.8	$12,912
658	Kidney & Ureter Procedures For Neoplasm w/o CC/MCC	1.7	$10,365
659	Kidney & Ureter Procedures For Non-Neoplasm w/MCC	5.9	$18,126
660	Kidney & Ureter Procedures For Non-Neoplasm w/CC	2.9	$9,423
661	Kidney & Ureter Procedures For Non-Neoplasm w/o CC/MCC	1.8	$7,340

See important notes on the uses and limitations of this information on page 3.

Lung

Physician, ASC, and Hospital Outpatient Coding and Medicare Allowable (CY 2024)

Service Provided		Physician Fee Schedule[1]			ASC[2]		Hospital Outpatient[3]		
CPT® Code	CPT® Description	RVUs	Non Facility	Facility	Payment	Status Indicator	APC	Status Indicator	Payment
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	9.03	$2,976	$419	$2,706	G2	5361	J1	$5,503
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	2.00	$97	$97	0	N1	NA	N	$0
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	3.99	$176	$176	$0	N1	NA	N	$0
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	4.24	$192	$192	$0	N1	NA	N	$0
32408	Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed	3.18	$824	$146	$683	G2	5072	J1	$1,546
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	0.67	$57	NA	$0	N1	NA	N	$0
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	0.54	$114	$26	$0	N1	NA	N	$0
77012	Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation	1.50	$137	$67	$0	N1	NA	N	$0
77021	Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	1.50	$418	$68	$0	N1	NA	N	$0
Unlisted Procedures									
32999	Unlisted procedure, lungs and pleura	0.00	$0	$0.00	NA	NA	5181	T	$599

The use of modifier 26 indicates that only the professional component of the procedure was provided.

CPT Modifier	Description
-26	Professional Component

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Lung

ICD-10-CM[4] DIAGNOSIS CODES (FY 2024)

The listed ICD-10-CM diagnosis codes are examples of codes that may apply for lung ablation procedures.

Code	ICD-10-CM Description (Diagnosis Codes)
C34.00	Malignant neoplasm of unspecified main bronchus
C34.01	Malignant neoplasm of right main bronchus
C34.02	Malignant neoplasm of left main bronchus
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.80	Malignant neoplasm of overlapping sites, unspecified bronchus or lung
C34.81	Malignant neoplasm of overlapping sites, right bronchus or lung
C34.82	Malignant neoplasm of overlapping sites, left bronchus or lung
C34.90	Malignant neoplasm of unspecified part, unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part, right bronchus or lung
C34.92	Malignant neoplasm of unspecified part, left bronchus or lung
C37	Malignant neoplasm of thymus
C38.4	Malignant neoplasm of pleura
C45.0	Mesothelioma of pleura
C76.1	Malignant neoplasm of thorax
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.1	Secondary malignant neoplasm of mediastinum
C7A.090	Malignant carcinoid tumor of the bronchus and lung
C7A.091	Malignant carcinoid tumor of the thymus
D02.20	Carcinoma in situ of unspecified bronchus and lung
D02.21	Carcinoma in situ of right bronchus and lung
D02.22	Carcinoma in situ of left bronchus and lung
D38.1	Neoplasm of uncertain behavior of trachea, bronchus and lung
D38.2	Neoplasm of uncertain behavior of pleura
D38.3	Neoplasm of uncertain behavior of mediastinum
D38.4	Neoplasm of uncertain behavior of thymus

See important notes on the uses and limitations of this information on page 3.

Lung

ICD-10-PCS[5] PROCEDURE CODES (FY 2024)

The listed ICD-10-PCS procedure codes are examples of codes that may apply for lung ablation procedures.

Code	ICD-10-PCS Description (Inpatient Procedure Codes)
0B533ZZ	Destruction of Right Main Bronchus, Percutaneous Approach
0B543ZZ	Destruction of Right Upper Lobe Bronchus, Percutaneous Approach
0B553ZZ	Destruction of Right Middle Lobe Bronchus, Percutaneous Approach
0B563ZZ	Destruction of Right Lower Lobe Bronchus, Percutaneous Approach
0B573ZZ	Destruction of Left Main Bronchus, Percutaneous Approach
0B583ZZ	Destruction of Left Upper Lobe Bronchus, Percutaneous Approach
0B593ZZ	Destruction of Lingula Bronchus, Percutaneous Approach
0B5B3ZZ	Destruction of Left Lower Lobe Bronchus, Percutaneous Approach
0B5C3ZZ	Destruction of Right Upper Lung Lobe, Percutaneous Approach
0B5D3ZZ	Destruction of Right Middle Lung Lobe, Percutaneous Approach
0B5F3ZZ	Destruction of Right Lower Lung Lobe, Percutaneous Approach
0B5G3ZZ	Destruction of Left Upper Lung Lobe, Percutaneous Approach
0B5H3ZZ	Destruction of Lung Lingula, Percutaneous Approach
0B5J3ZZ	Destruction of Left Lower Lung Lobe, Percutaneous Approach
0B5K3ZZ	Destruction of Right Lung, Percutaneous Approach
0B5L3ZZ	Destruction of Left Lung, Percutaneous Approach
0B5M3ZZ	Destruction of Bilateral Lungs, Percutaneous Approach
0B5N3ZZ	Destruction of Right Pleura, Percutaneous Approach
0B5P3ZZ	Destruction of Left Pleura, Percutaneous Approach
0B5T3ZZ	Destruction of Diaphragm, Percutaneous Approach
0B5_0ZZ	Destruction of [**see above**], Open Approach

Medicare Severity-Diagnosis Related Groups (MS-DRGs) [6,7] (FY 2024)

The following MS-DRGs may apply to lung ablation procedures for Medicare patients. Others may apply if additional procedures are performed, along with secondary ICD-10-CM diagnoses, during the same inpatient admission.

Service Provided		Hospital Inpatient	
MS- DRG[8]	MS-DRG Description	GMLoS (Days)	Hospital Payment
163	Major Chest Procedures w/MCC	7.5	$33,003
164	Major Chest Procedures w/CC	3.7	$17,857
165	Major Chest Procedures w/o CC/MCC	2.2	$13,138
166	Other Resp System O.R. Procedures w/MCC	8.4	$28,411
167	Other Resp System O.R. Procedures w/CC	3.5	$12,742
168	Other Resp System O.R. Procedures w/o CC/MCC	1.8	$9,492

See important notes on the uses and limitations of this information on page 3.

Prostate

Physician, ASC, and Hospital Outpatient Coding and Medicare Allowable (CY 2024)

Service Provided		Physician Fee Schedule[1]			ASC[2]		Hospital Outpatient[3]		
CPT® Code	CPT® Description	RVUs	Non Facility	Facility	Payment	Status Indicator	APC	Status Indicator	Payment
53852	Transurethral destruction of prostate tissue; by radiofrequency thermotherapy	5.93	$1,349	$376	$1,131	P3	5374	J1	$3,325
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	2.00	$97	$97	0	N1	NA	N	$0
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	4.24	$192	$192	$0	N1	NA	N	$0
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	2.50	$237	$126	$930	A2	5373	J1	$1,943
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	0.67	$57	$29	$0	N1	NA	N	$0
77021	Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	1.50	$418	$68	$0	N1	NA	N	$0
77021	Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	1.50	$418	$68	$0	N1	NA	N	$0
Unlisted Procedures									
53899	Unlisted procedure, urinary system	0.00	$0	$0	NA	NA	5371	T	$236

The use of modifier 26 indicates that only the professional component of the procedure was provided.

CPT Modifier	Description
-26	Professional Component

ICD-10-CM[4] DIAGNOSIS CODES (FY 2024)

The listed ICD-10-CM diagnosis codes are examples of codes that may apply for prostate ablation procedures.

Code	ICD-10-CM Description (Diagnosis Codes)
C61	Malignant neoplasm of prostate

ICD-10-PCS[5] PROCEDURE CODES (FY 2024)

The listed ICD-10-PCS procedure codes are examples of codes that may apply for prostate ablation procedures.

Code	ICD-10-PCS Description (Inpatient Procedure Codes)
0V503ZZ	Destruction of prostate, percutaneous approach

See important notes on the uses and limitations of this information on page 3.

Prostate

Medicare Severity-Diagnosis Related Groups (MS-DRGs) [6,7] (FY 2024)

The following MS-DRGs may apply to prostate ablation procedures for Medicare patients. Others may apply if additional procedures are performed, along with secondary ICD-10-CM diagnoses, during the same inpatient admission.

Service Provided		Hospital Inpatient	
MS- DRG[8]	MS-DRG Description	GMLoS (Days)	Hospital Payment
665	Prostatectomy w/MCC	7.9	$21,629
666	Prostatectomy w/CC	3.8	$12,025
667	Prostatectomy w/o CC/MCC	2	$7,349
707	Major Male Pelvic Disorders w/CC/MCC	2.2	$13,736
708	Major Male Pelvic Disorders w/o CC/MCC	1.4	$10,212

See important notes on the uses and limitations of this information on page 3.

Other

Physician, ASC, and Hospital Outpatient Coding and Medicare Allowable (CY 2024)

Service Provided		Physician Fee Schedule[1]			ASC[2]		Hospital Outpatient[3]		
CPT® Code	CPT® Description	RVUs	Non Facility	Facility	Payment	Status Indicator	APC	Status Indicator	Payment
40820	Destruction of lesion or scar of vestibule of mouth by physical methods (e.g., laser, thermal, cryo, chemical)	1.34	$255	$164	$207	P3	5164	J1	$3,071
41530	Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session	3.50	$895	$371	764.25	P3	5164	J1	$3,071
42160	Destruction of lesion, palate, or uvula (thermal, cryo or chemical)	1.85	$223	$139	$155	P3	5164	J1	$3,071
58353	Endometrial ablation, thermal, without hysteroscopic guidance	3.60	$905	$228	$2,136	A2	5415	J1	$4,744
58563	Hysteroscopy, surgical; with endometrial ablation (e.g., endometrial resection, electrosurgical ablation, thermoablation)	4.47	$2,052	$241	$2,136	A2	5415	J1	$4,744
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	14.08	NA	$802	$4,541	G2	5362	J1	$9,818
0404T	Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency	#N/A	#N/A	#N/A	$0	D5	NA	D	$0
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	2.00	$97	$97	$0	N1	NA	N	$0
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	3.99	$176	$176	$0	N1	NA	N	$0
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	4.24	$192	$192	$0	N1	NA	N	$0
Unlisted Procedures									
19499	Unlisted procedure, breast	0.00	$0	$0	NA	NA	5091	J1	$3,636
38589	Unlisted laparoscopy procedure, lymphatic system	0.00	$0	$0	NA	NA	5361	J1	$5,503
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum	0.00	$0	$0	NA	NA	5361	J1	$5,503
49999	Unlisted procedure, abdomen, peritoneum and omentum	0.00	$0	$0	NA	NA	5301	T	$865
60699	Unlisted procedure, endocrine system	0.00	$0	$0	NA	NA	5361	J1	$5,503

The use of modifier 26 indicates that only the professional component of the procedure was provided.

CPT Modifier	Description
-26	Professional Component

See important notes on the uses and limitations of this information on page 3.

Other

ICD-10-CM[4] DIAGNOSIS CODES (FY 2024)

The listed ICD-10-CM diagnosis codes are examples of codes that may apply for other soft tissue ablation procedures.

Code	ICD-10-CM Description (Diagnosis Codes)
C06.1	Malignant neoplasm of vestibule of mouth
C01	Malignant neoplasm of base of tongue
C02.0	Malignant neoplasm of dorsal surface of tongue
C02.1	Malignant neoplasm of border of tongue
C02.2	Malignant neoplasm of ventral surface of tongue
D00.07	Carcinoma in situ of tongue
D37.02	Neoplasm of uncertain behavior of tongue
C46.2	Kaposi's sarcoma of palate
D00.04	Carcinoma in situ of soft palate
D00.05	Carcinoma in situ of hard palate
N80.0	Endometriosis of uterus
N93.8	Other specified abnormal uterine and vaginal bleeding
D25.0	Submucous leiomyoma of uterus
D25.1	Intramural leiomyoma of uterus
D25.2	Subserosal leiomyoma of uterus
C50	Malignant neoplasm of breast [requires specificity C50.011 - C50.929]
C49	Malignant neoplasm of other connective and soft tissue [requires specificity C49.0 - C49.A9]
D21	Other benign neoplasms of connective and other soft tissue [requires specificity D21.0 - D21.9]
C74	Malignant neoplasm of adrenal gland [requires specificity C74.00 - C74.92]
C73	Malignant neoplasm of thyroid gland
C75	Malignant neoplasm of other endocrine glands and related structures [requires specificity C75.0 - C75.9]

ICD-10-PCS[5] PROCEDURE CODES (FY 2024)

The listed ICD-10-PCS procedure codes are examples of codes that may apply for other soft tissue ablation procedures.

Code	ICD-10-PCS Description (Inpatient Procedure Codes)
0C533ZZ	Destruction of Soft Palate, Percutaneous Approach
0C543ZZ	Destruction of Buccal Mucosa, Percutaneous Approach
0C573ZZ	Destruction of Tongue, Percutaneous Approach
0K543ZZ	Destruction of Tongue, Palate, Pharynx Muscle, Percutaneous Approach
0U5B3ZZ	Destruction of Endometrium, Percutaneous Approach
0U5B7ZZ	Destruction of Endometrium, Via Opening
0U594ZZ	Destruction of Uterus, Percutaneous Endoscopic Approach
0U597ZZ	Destruction of Uterus, Via Natural or Artificial Opening
0H5T3ZZ	Destruction of Right Breast, Percutaneous Approach
0H5U3ZZ	Destruction of Left Breast, Percutaneous Approach
075_4ZZ	Destruction of_____, Percutaneous Endoscopic Approach
075M3ZZ	Destruction of Thymus, Percutaneous Approach
0G523ZZ	Destruction of Left Adrenal Gland, Percutaneous Approach
0G533ZZ	Destruction of Right Adrenal Gland, Percutaneous Approach
0G5G3ZZ	Destruction of Left Thyroid Gland Lobe, Percutaneous Approach
0G5H3ZZ	Destruction of Right Thyroid Gland Lobe, Percutaneous Approach
0G5K3ZZ	Destruction of Thyroid Gland, Percutaneous Approach

See important notes on the uses and limitations of this information on page 3.

Other

Medicare Severity-Diagnosis Related Groups (MS-DRGs) [6,7] (FY 2024)

The following MS-DRGs may apply to other soft tissue ablation procedures for Medicare patients. Others may apply if additional procedures are performed, along with secondary ICD-10-CM diagnoses, during the same inpatient admission.

Service Provided		Hospital Inpatient	
MS- DRG[8]	MS-DRG Description	GMLoS (Days)	Hospital Payment
137	Mouth Procedures w/CC/MCC	3.7	$10,535
138	Mouth Procedures w/o CC/MCC	1.6	$6,061
500	Soft Tissue Procedures w/MCC	7.8	$22,705
501	Soft Tissue Procedures w/CC	4.1	$12,153
502	Soft Tissue Procedures w/o CC/MCC	2.3	$9,681
579	Other Skin, Subcutaneous Tissue & Breast Procedures w/MCC	8	$23,401
580	Other Skin, Subcutaneous Tissue & Breast Procedures w/CC	4.1	$12,229
581	Other Skin, Subcutaneous Tissue & Breast Procedures w/o CC/MCC	2.1	$9,429
584	Breast Biopsy, Local Excision & Other Breast Procedures w/CC/MCC	3.5	$13,713
585	Breast Biopsy, Local Excision & Other Breast Procedures w/o CC/MCC	2.1	$11,791
614	Adrenal & Pituitary Procedures w/CC/MCC	2.8	$15,770
615	Adrenal & Pituitary Procedures w/o CC/MCC	1.6	$10,300
625	Thyroid, Parathyroid & Thyroglossal Procedures w/MCC	5.1	$20,453
626	Thyroid, Parathyroid & Thyroglossal Procedures w/CC	2	$10,446
627	Thyroid, Parathyroid & Thyroglossal Procedures w/o CC/MCC	1.3	$8,654
628	Other Endocrine, Nutritional & Metabolic O.R. Procedures w/MCC	8.4	$28,108
629	Other Endocrine, Nutritional & Metabolic O.R. Procedures w/CC	6.2	$15,843
630	Other Endocrine, Nutritional & Metabolic O.R. Procedures w/o CC/MCC	2.1	$9,776
736	Uterine & Adnexa Procedures, Ovarian Or Adnexal Malignancy w/MCC	7.9	$27,217
737	Uterine & Adnexa Procedures, Ovarian Or Adnexal Malignancy w/CC	3.9	$13,820
738	Uterine & Adnexa Procedures, Ovarian Or Adnexal Malignancy w/o CC/MCC	2.3	$9,554
739	Uterine & Adnexa Procedures, Non-Ovarian & Non-Adnexal Malignancy w/MCC	6.3	$25,320
740	Uterine & Adnexa Procedures, Non-Ovarian & Non-Adnexal Malignancy w/CC	2.7	$12,512
741	Uterine & Adnexa Procedures, Non-Ovarian & Non-Adnexal Malignancy w/o CC/MCC	1.6	$9,097
742	Uterine & Adnexa Procedures, Non-Malignancy w/CC/MCC	2.7	$12,476
743	Uterine & Adnexa Procedures, Non-Malignancy w/o CC/MCC	1.6	$8,136
820	Lymphoma & Leukemia W Major O.R. Procedures w/MCC	11.9	$42,337
821	Lymphoma & Leukemia W Major O.R. Procedures w/CC	3.6	$15,628
822	Lymphoma & Leukemia W Major O.R. Procedures w/o CC/MCC	1.6	$8,674
823	Lymphoma & Non-Acute Leukemia W Other Procedures w/MCC	10.5	$31,521
824	Lymphoma & Non-Acute Leukemia W Other Procedures w/CC	5.1	$15,634
825	Lymphoma & Non-Acute Leukemia W Other Procedures w/o CC/MCC	2.2	$9,042
826	Myeloproliferative Disorders Or Poorly Diff Neoplasms W Major O.R. Procedures w/MCC	8.7	$30,729
827	Myeloproliferative Disorders Or Poorly Diff Neoplasms W Major O.R. Procedures w/CC	4.2	$16,224
828	Myeloproliferative Disorders Or Poorly Diff Neoplasms W Major O.R. Procedures w/o CC/MCC	2.5	$11,485
907	Other O.R. Procedures For Injuries w/MCC	6.9	$26,042
908	Other O.R. Procedures For Injuries w/CC	3.8	$14,032
909	Other O.R. Procedures For Injuries w/o CC/MCC	2.3	$9,496

See important notes on the uses and limitations of this information on page 3.

Other

Medicare Severity-Diagnosis Related Groups (MS-DRGs) [6,7] (FY 2024) *Continued*

The following MS-DRGs may apply to other soft tissue ablation procedures for Medicare patients. Others may apply if additional procedures are performed, along with secondary ICD-10-CM diagnoses, during the same inpatient admission.

Service Provided		Hospital Inpatient	
MS- DRG[8]	MS-DRG Description	GMLoS (Days)	Hospital Payment
957	Other O.R. Procedures For Multiple Significant Trauma w/MCC	10	$50,639
958	Other O.R. Procedures For Multiple Significant Trauma w/CC	6.7	$28,320
959	Other O.R. Procedures For Multiple Significant Trauma w/o CC/MCC	4	$17,731
987	Non-Extensive O.R. Procedures Unrelated To Pdx w/MCC	8.2	$23,642
988	Non-Extensive O.R. Procedures Unrelated To Pdx w/CC	4.3	$11,882
989	Non-Extensive O.R. Procedures Unrelated To Pdx w/o CC/MCC	2.3	$7,564

See important notes on the uses and limitations of this information on page 3.

Medicare Legend Indicators

PFS Indicator

NF NA – Non-Facility Not Available. Service paid at Facility Practice Expense (PE) RVU (Relative Value Unit) rate.

ASC Indicators

G2 - Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
N1 - Packaged service/item; no separate payment made.
A2 - Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
C - Hospital inpatient procedure.
NP – Unlisted procedure codes are not payable in an ASC.

OPPS APC Indicators

J1 - Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; services assigned to a new technology APC; self-administered drugs; all preventive services; and certain Part B inpatient services.
N - Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC assigned code or payment.
C - Not paid under OPPS. Admit patient. Bill as inpatient.
T - Procedure or Service, Multiple Procedure Reduction Applies. Paid under OPPS; separate APC payment.

MS-DRG Definitions

MCC – Major Complications and Comorbidities
CC – Complications and Comorbidities
Relative Weight - A numeric value that reflects the relative resource consumption for the DRG to which it is assigned.
GMLoS - Geometric Mean Length of Stay

Disclaimer

The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

See important notes on the uses and limitations of this information on page 3.

Device Coding

There are no HCPCS C codes that describe probes used in radiofrequency ablation procedures.

Sources

1. FY 2024 IPPS Payment. CMS-1785-F. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page
2. CMS 2024 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-pcs
3. CMS ICD-10-CM/PCS MS-DRG V41.0 Definitions Manual. https://www.cms.gov/files/zip/icd-10-ms-drg-definitions-manual-files-v41.zip
   Not intended as an all-inclusive list of MS-DRGs
4. 2024 Physician Fee Schedule. CMS-1784-F. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1784-f
   2024 *Conversion Factor of $32.7442*
5. 2024 ASC Payment. CMS-1786-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc
6. 2024 OPPS Payment. CMS-1786-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc

See important notes on the uses and limitations of this information on page 3.

Medicare Payment Descriptions

Physician Billing and Payment: Medicare and most other insurers typically reimburse physicians based on fee schedules tied to CPT® codes. CPT codes are published by the AMA and used to report medical services and procedures. Physician payment for procedures performed in a hospital (outpatient or inpatient) or Ambulatory Surgical Center (ASC) setting is described as a Facility fee payment while payment for proceduresperformed in the physician office is described as a Non-Facility or Global payment. Facility payments use modifier -26 as applicable.

Hospital Outpatient Billing and Payment: Medicare reimburses hospitals for outpatient stays (typically stays that do not span 2 midnights) under Ambulatory Payment Classification (APC) groups. Medicare assigns an APC to a procedure based on the billed CPT/HCPCS (Healthcare Common Procedural Coding System) code. While it is possible that separate APC payments may be deemed appropriate where more than one procedure is done during the same outpatient visit, many APCs are subject to reduced payment when multiple procedures are performed on the same day. Comprehensive APCs (J1 status indicator) can impact total payment received for outpatient services.

Hospitals and Medical Devices: Hospitals must report device category codes (HCPCS C-codes) on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPPS. This reporting provides claims data used annually to update the OPPS payment rates. Although separate payment is not typically available for C-Codes, denials may result if applicable C- Codes are not included with associated procedure codes. CMS has an established cost center for "Implantable Devices Charged to Patients" and uses data from this cost center to establish OPPS payments.

Hospital Inpatient Billing and Payment: Medicare reimburses hospital inpatient procedures based on the Medicare Severity Diagnosis RelatedGroup (MS-DRG). The MS-DRG is a system of classifying patients based on their diagnoses and the procedures performed during their hospital stay. MS-DRGs closely calibrate payment to the severity of a patient's illness. One single MS-DRG payment is intended to cover all hospital costs associated with treating an individual during his or her hospital stay, except for "professional" (e.g., physician) charges associated with performing medical procedures.

ICD-10-PCS: Potential hospital inpatient procedure codes are included within this guide. Due to the number of potential codes within the ICD-10- PCS system, the codes included in this document do not fully account for all procedure code options. Some codes outlined in this guide include an " _" symbol. In these examples, the "_" character could be any possible alphanumeric value depending on the procedure category. The "_" symbol is not a recognized character within the ICD-10-PCS system.

ASC Billing and Payment: Many elective procedures are performed outside of the hospital in Medicare certified facilities also known as ASCs. Not all procedures that Medicare covers in the hospital setting are eligible for payment in an ASC. Medicare has a list of all services (as defined byCPT/HCPCs codes), that it covers when offered in an ASC.

Sequestration Disclaimer: Rates referenced in these guides do not reflect Sequestration; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates (Budget Control Act of 2011). **Update**: The Coronavirus Aid, Relief, and Economic Security (CARES) Act suspended the payment adjustment percentage of 2% applied to all Medicare Fee-For-Service (FFS) claims from May 1, 2020 through December 31, 2020. The Consolidated Appropriations Act, 2021, signed into law on December 27, 2020, extends the suspension period to March 31, 2021.

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