

Radiofrequency Ablation

Boston
Scientific

Liver Reimbursement Information

2009 CODING & PAYMENT QUICK REFERENCE

MEDICARE PHYSICIAN, HOSPITAL, AND ASC PAYMENTS

CPT® Code ¹	Code Description	Physician ²		Facility ³	
		MD Payment In-office	MD Payment In-facility	Hospital Outpatient Payment	ASC Payment
47370	Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency	NA*	\$1,126	\$7,909	NA**
47382	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	NA*	\$822	\$3,072	\$1,877
47380	Ablation, open, of one or more liver tumor(s); radiofrequency	NA*	\$1,316	NA***	NA**

RADIOLOGIC SUPERVISION & INTERPRETATION CODES

- In 2002, the AMA created CPT codes for radiologic supervision & interpretation of radiofrequency ablation procedures. There are two components to these codes: technical and professional. We have only referenced the professional component that represents the payment to the physician for reading and interpreting the results.
- These codes are not specific to an anatomic location and can be used in all soft tissue applications.
- Effective January 1, 2007, CPT code 76940 has been revised with the deletion of the term “visceral” to specify the use of this ultrasound imaging code for the monitoring and guidance of parenchymal tissue ablation procedures. In addition, codes 77013 and 77022 were created to replace 76362 and 76394, respectively to allow for more appropriate placement in the new subsections for Computed Tomographic Guidance and Magnetic Resonance Guidance.

CPT® Code ¹	Code Description	MD Payment ⁴	Hospital Outpatient Payment ³
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	\$108	\$0
77013	Computerized axial tomographic guidance for, and monitoring of, parenchymal tissue ablation	\$205	\$0
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	\$215	\$0

*NA = Medicare has not developed a rate for the In-Office setting as the procedure is typically performed in the hospital setting. If the contractor determines the service can be performed in-office, it will be paid at the MD In-facility rate.

**NA = Procedure is not on Medicare's approved list of procedures in the ASC setting.

***NA= Inpatient procedure, Medicare did not develop a rate for outpatient hospital setting.

¹Source: Beebe et al. (2008). *CPT®2009 Professional Edition*. Chicago: American Medical Association. CPT® is a registered trademark of American Medical Association. All Rights Reserved.

²Source: November 19, 2008 Federal Register. MD payments calculated using the 2009 conversion factor of \$36.066.

³Source: November 18, 2008 Federal Register.

⁴Professional component only used for calculating imaging procedure payment.

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MEDICARE HOSPITAL INPATIENT PAYMENT

Effective October 1, 2007, the Center for Medicare and Medicaid Services (CMS) is replacing the Diagnosis Related Groups (DRG) System with the Medicare-Severity DRG (MS-DRG) classification system to recognize severity of illness among patients. The new system, which will be phased in over a two-year period, expands the current list of 538 DRGs to a new list of 745 "severity-adjusted" DRGs.

ICD-9-CM Procedure Code	ICD-9-CM Diagnosis Code	Possible MS-DRG Assignment ⁴
50.24- Percutaneous ablation of liver lesion or tissue	155.0 - Malignant neoplasm of liver, primary	MS-DRG 405 Pancreas, liver and shunt procedures with major complication or comorbidity (MCC) \$31,319 ⁵
50.25- Laparoscopic ablation of liver lesion or tissue	155.2 - Malignant neoplasm of liver, not specified as primary or secondary	MS-DRG 406 Pancreas, liver and shunt procedures with complication or comorbidity (CC) \$15,468 ⁵
50.23- Open ablation of liver lesion or tissue	197.7 - Secondary malignant neoplasm of liver	MS-DRG 407 Pancreas, liver and shunt procedures without CC/MCC \$10,210
	211.5 - Benign neoplasm of liver and biliary passages	

⁴ National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5552.58). Source: October 3, 2008 Federal Register

⁵The patient's medical record must support the existence and treatment of the complication or comorbidity.

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