

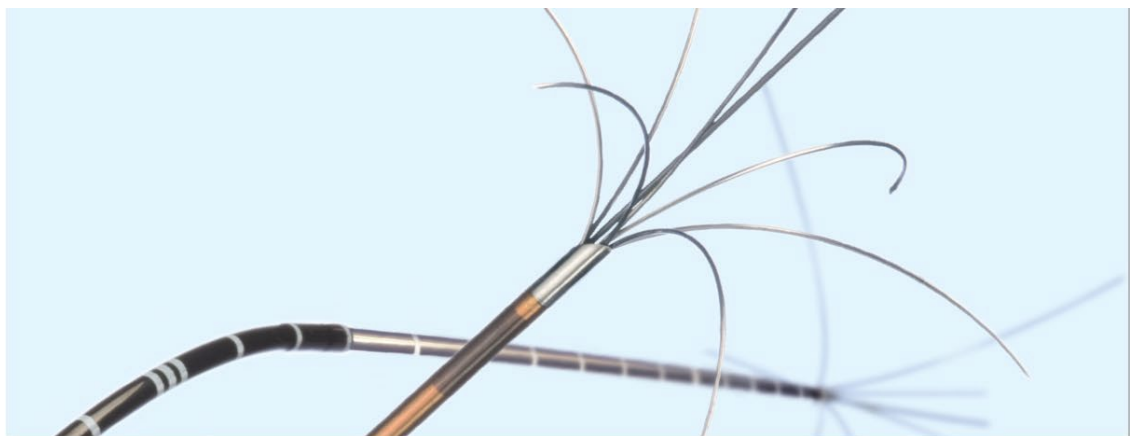
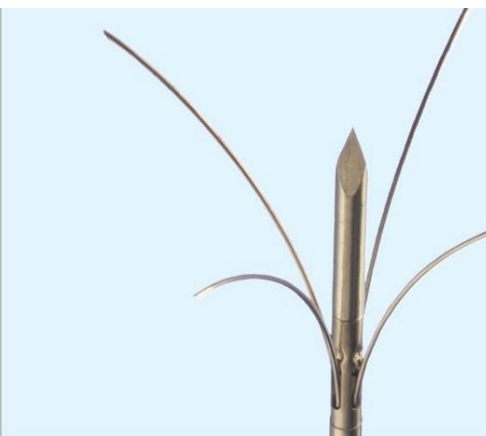


Reimbursement Guidelines

2023 **Microwave and Radiofrequency Ablation**

Reimbursement Coding Guide

EFFECTIVE JANUARY 1, 2023



This is general reimbursement information only and is intended to assist in the compliance of complex and changing reimbursement policies. It is not legal advice, nor is it advice about how to code, complete, or submit any particular claim for payment, nor is it intended to increase or maximize reimbursement by any third-party payor. This information has been gathered from third-party sources and was correct at the time of publication and is subject to change without notice. It is the provider's responsibility to exercise independent clinical judgment to determine appropriate coding and charges that accurately reflect all the patient's conditions and services provided. These should be recorded in the patient's medical record. The information provided here is for informational purposes only and represents no statement, promise or guarantee by AngioDynamics concerning levels of reimbursement, payment, or charges.

Payors may have their own coding and reimbursement requirements and policies. If reimbursement questions arise for a particular patient, providers should contact the payor to confirm current requirements and billing policies. All decisions related to reimbursement, including amounts to bill, are exclusively that of the provider. Providers should check and confirm coding from complete and authoritative coding sources to ensure accuracy. This document is not intended to promote the off-label use of medical devices and physicians should use medical devices fully consistent with all government requirements. The content is not intended to instruct hospitals and/or physicians on how to use medical devices or bill for healthcare procedures. CPT codes © 2023 American Medical Association. All Rights Reserved. CPT® is a trademark of the AMA. Applicable FARS/DFARS restrictions apply to Government Use. US/ON/MS/49 Rev 08 1/2023

Table of Contents

Table of Contents	2
Liver Microwave & Radiofrequency Ablation	3
PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT	3
ICD-10-CM DIAGNOSIS CODES	4
ICD-10-PCS PROCEDURE CODES	4
Medicare Severity-Diagnosis Related Groups (MS-DRGs)	5
Kidney Microwave & Radiofrequency Ablation	6
PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT	6
ICD-10-CM DIAGNOSIS CODES	7
ICD-10-PCS PROCEDURE CODES	7
Medicare Severity-Diagnosis Related Groups (MS-DRGs)	8
Lung Microwave & Radiofrequency Ablation	9
PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT	9
ICD-10-CM DIAGNOSIS CODES	10
ICD-10-PCS PROCEDURE CODES	11
Bone Radiofrequency Ablation	12
PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT	12
ICD-10-CM DIAGNOSIS CODES	12
ICD-10-PCS PROCEDURE CODES	13
Medicare Severity-Diagnosis Related Groups (MS-DRGs)	15
Other Soft Tissue Microwave & Radiofrequency Ablation	17
PHYSICIAN, HOSPITAL OPPTS, ASC CODING & PAYMENT	17
Reimbursement Terminology	18
References	19

Liver Microwave & Radiofrequency Ablation

Physician, Hospital OPPS, ASC Coding & Payment (January 2023 - December 2023)

According to an American Medical Association (AMA) and American College of Radiology (ACR) co-publication¹, "microwave is part of the radiofrequency spectrum, and simply uses a different part of the radiofrequency spectrum to develop heat energy to destroy abnormal tissue." Therefore, the AMA/ACR recommends that microwave ablation be reported using CPT® codes for radiofrequency ablation. Below is a list of commonly reported CPT codes for liver tumor ablations and Medicare national average payment rates.

Medicare 2023 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Reimbursement ³				Hospital OPPS Payment ⁴		ASC Payment ⁵ (Payment Indicator)
CPT® Code ²	CPT® Description ²	Non-Facility		Facility		APC ⁴ (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	N/A	N/A	37.47	\$1,269.75	5362 (J1)	\$9,087.30	N/A
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	111.00	\$3,761.48	21.59	\$731.62	5361 (J1)	\$5,212.15	\$2,498.70 (G2)
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	\$178.53 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
77022	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	\$198.03 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	\$97.53 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
Open Liver Procedure (Medicare "Inpatient Only" Procedures)								
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	N/A	N/A	43.13	\$1,461.55	No APC code (C)	Not Covered	Not Covered
Unlisted Procedures								
47399	Unlisted procedure, liver ⁶	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5071 (T)	\$648.97	Not Covered

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 Diagnosis Codes (October 2022 - September 2023)

Diagnosis codes are used by physicians and hospitals to document all patient conditions associated with the hospitalization. Secondary diagnosis codes corresponding to additional conditions at the time of admission, or developed subsequently, and which influence the treatment received or the length of stay should be reported. The ICD-10-CM codes below are examples of diagnosis codes that may apply for liver tumor indications^{7,8}. The provider should refer to a complete coding authority to check, confirm, and report all codes that accurately describe all the patient's conditions.

ICD-10-CM ^{7,8}	ICD-10-CM Description (Diagnosis Codes) ^{7,8}
C22.0	Liver cell carcinoma
C22.1	Intrahepatic bile duct carcinoma
C22.2	Hepatoblastoma
C22.3	Angiosarcoma of liver
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
C7A.8	Other malignant neuroendocrine tumors
C7B.02	Secondary carcinoid tumors of liver
C7B.8	Other secondary neuroendocrine tumors

ICD-10-PCS Procedure Codes (October 2022 - September 2023)

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

ICD-10-PCS Code ⁹	ICD-10-PCS Description (Procedure Codes) ⁹
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, Perc Endo Approach

Medicare Severity-Diagnosis Related Groups (MS-DRGs) (October 2022 - September 2023)

The following MS-DRGs may apply to liver tumor ablation procedures for Medicare patients. If significant additional procedures are performed during the same inpatient admission, other MS-DRGs may apply.

MS-DRG ^{10,11}	MS-DRG Description ^{10,11}	2023 Relative Weight ¹⁰	2023 Medicare Payment ¹⁰
356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	4.2225	\$28,964.24
357	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.2462	\$15,407.81
358	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3872	\$9,515.50
405	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.5419	\$38,014.66
406	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.9297	\$20,096.28
407	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	2.2257	\$15,267.19

HCPCS Codes

Healthcare Common Procedure Coding System (HCPCS) Level II codes were developed to help categorize, document, and track the use of products, supplies, and services. HCPCS codes should be reported for all device-dependent Ambulatory Payment Classifications (APCs) for procedures conducted in the hospital outpatient setting. While HCPCS codes do not generally result in additional payment, it is important for hospitals to use HCPCS codes as a means of cost reporting which CMS uses to help determine future payment rates. The HCPCS codes listed below may be used for endovenous ablation procedures.

HCPCS Code ¹²	HCPCS Description ¹²	MWA/RF System(s) Product
C1889	Implantable/insertable device, not otherwise classified	MWA/RF Ablation Probes

Kidney Microwave & Radiofrequency Ablation

Physician, Hospital OPPS, ASC Coding & Payment (January 1, 2023 To December 31, 2023)

According to an American Medical Association (AMA) and American College of Radiology (ACR) co-publication¹, "microwave is part of the radiofrequency spectrum, and simply uses a different part of the radiofrequency spectrum to develop heat energy to destroy abnormal tissue." Therefore, the AMA/ACR recommends that microwave ablation be reported using CPT® codes for radiofrequency ablation. The listed CPT® codes in the table below are examples of codes that may apply to kidney tumor ablation procedures and Medicare national average payment rates.

Medicare 2023 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule ³				Hospital OPPS Payment ⁴		ASC Payment ⁵ (Payment Indicator)
CPT® Code ²	CPT® Description ²	Non-Facility		Facility		APC Code ⁴ (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	N/A	N/A	34.36	\$1,164.36	5362 (J1)	\$9,0987.30	N/A
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	85.60	\$2,900.74	10.04	\$340.23	5361 (J1)	\$5,212.15	\$2,498.70 (G2)
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	\$185.14 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
77022	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	\$205.91 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	\$101.40 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
Unlisted Procedures								
53899	Unlisted procedure, urinary system ¹³	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5371 (T)	\$214.87	Not Covered

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 Diagnosis Codes (October 2022 - September 2023)

Diagnosis codes are used by physicians and hospitals to document all patient conditions associated with the hospitalization. Secondary diagnosis codes corresponding to additional conditions at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay should be reported. The codes below are examples of diagnosis codes that may apply for kidney tumor indications^{7,8}. The provider should check a complete and authoritative coding source to confirm and report all codes that accurately describe all the patient's conditions.

ICD-10-CM Code ^{7,8}	ICD-10-CM Description ^{7,8}
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 Procedure Codes (October 2022 - September 2023)

The listed ICD-10-PCS procedure codes are examples of codes that may apply for *kidney tumor ablation* procedures⁹.

ICD-10-PCS Code ⁹	ICD-10-PCS Description (Procedure Codes) ⁹
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) (October 2022 - September 2023)

The following MS-DRGs may apply to kidney tumor ablation procedures for Medicare patients^{10,11}. If significant additional procedures are performed during the same inpatient admission, other MS-DRGs may apply.

MS-DRG ^{10,11}	MS-DRG Description ^{10,11}	2023 Relative Weight ¹⁰	2023 Medicare Payment ¹⁰
656	KIDNEY & URETER PROC FOR NEOPLASM W MCC	3.3053	\$22,672.71
657	KIDNEY & URETER PROC FOR NEOPLASM W CC	1.878	\$12,882.14
658	KIDNEY & URETER PROC FOR NEOPLASM W/O CC/MCC	1.579	\$10,831.15
659	KIDNEY & URETER PROC FOR NON-NEOPLASM W MCC	2.5769	\$17,676.25
660	KIDNEY & URETER PROC FOR NON-NEOPLASM W CC	1.4112	\$9,680.13
661	KIDNEY & URETER PROC FOR NON-NEOPLASM W/O CC/MCC	1.0779	\$7,393.86

HCPCS Codes

Healthcare Common Procedure Coding System (HCPCS) Level II codes were developed to help categorize, document, and track the use of products, supplies, and services. HCPCS codes should be reported for all device-dependent Ambulatory Payment Classifications (APCs) for procedures conducted in the hospital outpatient setting. While HCPCS codes do not generally result in additional payment, it is important for hospitals to use HCPCS codes as a means of cost reporting which CMS uses to help determine future payment rates. The HCPCS codes listed below may be used for endovenous ablation procedures.

HCPCS Code ¹²	HCPCS Description ¹²	MWA/RF System(s) Product
C1889	Implantable/insertable device, not otherwise classified	MWA/RF Ablation Probes

Lung Microwave & Radiofrequency Ablation

Physician, Hospital OPPS, ASC Coding & Payment (January 2023 - December 2023)

According to an American Medical Association (AMA) and American College of Radiology (ACR) co-publication¹, "microwave is part of the radiofrequency spectrum, and simply uses a different part of the radiofrequency spectrum to develop heat energy to destroy abnormal tissue." Therefore, the AMA/ACR recommends that microwave ablation be reported using CPT® codes for radiofrequency ablation. The listed CPT® codes in the table below are examples of codes that may apply to lung tumor ablation procedures and Medicare national average payment rates.

Medicare 2023 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Reimbursement ³				Hospital OPPS Payment ⁴		ASC Payment ⁵ (Payment Indicator)
CPT® Code ²	CPT® Description ²	Non-Facility		Facility		APC Code ⁴ (Status Indicator)	Payment	
		RVUs	Payment	RVUs	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	94.35	\$3,197.26	12.84	\$435.11	5361 (J1)	\$5,212.15	\$2,498.70 (G2)
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	\$178.52 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
77022	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	\$198.03 (Professional Fee Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	\$97.53 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
Unlisted Procedures								
32999	Unlisted procedure, lungs and pleura ¹⁴	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5181 (T)	\$578.50	Not Covered

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 Diagnosis Codes (October 2022 - September 2023)

Diagnosis codes are used by physicians and hospitals to document all patient conditions associated with the hospitalization. Secondary diagnosis codes corresponding to additional conditions at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay should be reported. The codes below are examples of diagnosis codes that may apply for lung tumor indications.^{7,8} The provider should check a complete and authoritative coding source to confirm and report all codes that accurately describe all the patient's conditions.

ICD-10-CM Code ^{7,8}	ICD-10-CM Description ^{7,8}
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 of unspecified bronchus and lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
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
C78.2	Secondary malignant neoplasm of pleura
C7A.090	Malignant carcinoid tumor of the bronchus and lung

ICD-10-PCS Procedure Codes (October 2022 - September 2023)

The listed ICD-10-PCS procedure codes are examples that may apply for lung tumor ablation procedures⁹.

ICD-10-PCS Code ⁹	ICD-10-PCS Description ⁹
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
0B5C0ZZ	Destruction of Right Upper Lung Lobe, Open Approach
0B5D0ZZ	Destruction of Right Middle Lung Lobe, Open Approach
0B5F0ZZ	Destruction of Right Lower Lung Lobe, Open Approach
0B5G0ZZ	Destruction of Left Upper Lung Lobe, Open Approach
0B5H0ZZ	Destruction of Lung Lingula, Open Approach
0B5J0ZZ	Destruction of Left Lower Lung Lobe, Open Approach
0B5K0ZZ	Destruction of Right Lung, Open Approach
0B5L0ZZ	Destruction of Left Lung, Open Approach
0B5M0ZZ	Destruction of Bilateral Lungs, Open Approach
0B5N0ZZ	Destruction of Right Pleura, Open Approach
0B5P0ZZ	Destruction of Left Pleura, Open Approach

Medicare Severity-Diagnosis Related Groups (MS-DRGs) (October 2022 - September 2023)

The following MS-DRGs may apply to lung tumor ablation procedures for Medicare patients^{14,15}. If significant additional procedures are performed during the same inpatient admission, other MS-DRGs may apply.

MS-DRG ^{10,11}	MS-DRG Description ^{10,11}	2023 Relative Weight ¹⁰	2023 Medicare Payment ¹⁰
163	MAJOR CHEST PROCEDURES W MCC	4.8437	\$33,225.36
164	MAJOR CHEST PROCEDURES W CC	2.5827	\$17,716.03
165	MAJOR CHEST PROCEDURES W/O CC/MCC	1.9269	\$13,217.57
166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.6658	\$25,145.56
167	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.9011	\$13,040.60
168	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.4176	\$9,724.03

Bone Radiofrequency Ablation

Physician, Hospital OPPS, ASC Coding & Payment (January 2023 - December 2023)

The listed CPT® codes are examples of codes that may apply for bone tumor ablation procedures and Medicare national average payment rates.

Medicare 2023 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule ³				Hospital OPPS Payment ⁴		ASC Payment ⁵ (Payment Indicator)
CPT® Code ²	CPT® Description ²	Non-Facility		Facility		APC Code ⁴ (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
20982	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; radiofrequency	106.04	\$3,593.40	10.81	\$366.32	5114 (J1)	\$6,614.63	\$4,008.70 (G2)

ICD-10-CM Diagnosis Codes (October 2022 - September 2023)

Diagnosis codes are used by physicians and hospitals to document all patient conditions associated with the hospitalization. Secondary diagnosis codes corresponding to additional conditions at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay should be reported. The codes below are examples of diagnosis codes that may apply for bone tumor indications^{7,8}. The provider should check a complete and authoritative coding source to confirm and report all codes that accurately describe all the patient's conditions.

ICD-10-CM Code ^{7,8}	ICD-10-CM Description ^{7,8}	ICD-10-CM Code ^{7,8}	ICD-10-CM Description (Diagnosis Codes) ^{7,8}
C40.00	Malignant neoplasm of scapula and long bones of unspecified upper limb	C40.90	Malignant neoplasm of unspecified bones and articular cartilage of unspecified limb
C40.01	Malignant neoplasm of scapula and long bones of right upper limb	C40.91	Malignant neoplasm of unspecified bones and articular cartilage of right limb
C40.02	Malignant neoplasm of scapula and long bones of left upper limb	C40.92	Malignant neoplasm of unspecified bones and articular cartilage of left limb
C40.10	Malignant neoplasm of short bones of unspecified upper limb	C41.0	Malignant neoplasm of bones of skull and face
C40.11	Malignant neoplasm of short bones of right upper limb	C41.1	Malignant neoplasm of mandible
C40.12	Malignant neoplasm of short bones of left upper limb	C41.2	Malignant neoplasm of vertebral column
C40.20	Malignant neoplasm of long bones of unspecified lower limb	C41.3	Malignant neoplasm of ribs, sternum and clavicle
C40.21	Malignant neoplasm of long bones of right lower limb	C41.4	Malignant neoplasm of pelvic bones, sacrum and coccyx
C40.22	Malignant neoplasm of long bones of left lower limb	C41.9	Malignant neoplasm of bone and articular cartilage, unspecified

ICD-10-CM Code ^{7,8}	ICD-10-CM Description ^{7,8}	ICD-10-CM Code ^{7,8}	ICD-10-CM Description (Diagnosis Codes) ^{7,8}
C40.30	Malignant neoplasm of short bones of unspecified lower limb	C76.0	Malignant neoplasm of head, face and neck
C40.31	Malignant neoplasm of short bones of right lower limb	C76.1	Malignant neoplasm of thorax

ICD-10-CM Code ^{7,8}	ICD-10-CM Description ^{7,8}	ICD-10-CM Code ^{7,8}	ICD-10-CM Description (Diagnosis Codes) ^{7,8}
C40.32	Malignant neoplasm of short bones of left lower limb	C76.3	Malignant neoplasm of pelvis
C40.80	Malignant neoplasm of overlapping sites of bone and articular cartilage of unspecified limb	C79.51	Secondary malignant neoplasm of bone
C40.81	Malignant neoplasm of overlapping sites of bone and articular cartilage of right limb	C79.52	Secondary malignant neoplasm of bone marrow
C40.82	Malignant neoplasm of overlapping sites of bone and articular cartilage of left limb	C7B.03	Secondary carcinoid tumors of bone

ICD-10-PCS Procedure Codes (October 2022 - September 2023)

The listed ICD-10-PCS procedure codes are examples that may apply for bone tumor ablation procedures⁹.

ICD-10-PCS Code ⁹	ICD-10-PCS Description ⁹
Head and Neck	
0N503ZZ	Destruction of Skull, Percutaneous Approach
0N513ZZ	Destruction of Frontal Bone, Percutaneous Approach
0N533ZZ	Destruction of Right Parietal Bone, Percutaneous Approach
0N543ZZ	Destruction of Left Parietal Bone, Percutaneous Approach
0N553ZZ	Destruction of Right Temporal Bone, Percutaneous Approach
0N563ZZ	Destruction of Left Temporal Bone, Percutaneous Approach
0N573ZZ	Destruction of Occipital Bone, Percutaneous Approach
0N5B3ZZ	Destruction of Nasal Bone, Percutaneous Approach
0N5C3ZZ	Destruction of Sphenoid Bone, Percutaneous Approach
0N5F3ZZ	Destruction of Right Ethmoid Bone, Percutaneous Approach
0N5G3ZZ	Destruction of Left Ethmoid Bone, Percutaneous Approach
0N5H3ZZ	Destruction of Right Lacrimal Bone, Percutaneous Approach
0N5J3ZZ	Destruction of Left Lacrimal Bone, Percutaneous Approach
0N5K3ZZ	Destruction of Right Palatine Bone, Percutaneous Approach
0N5L3ZZ	Destruction of Left Palatine Bone, Percutaneous Approach
0N5M3ZZ	Destruction of Right Zygomatic Bone, Percutaneous Approach
0N5N3ZZ	Destruction of Left Zygomatic Bone, Percutaneous Approach
0N5P3ZZ	Destruction of Right Orbit, Percutaneous Approach
0N5Q3ZZ	Destruction of Left Orbit, Percutaneous Approach
0N5R3ZZ	Destruction of Maxilla, Percutaneous Approach
0N5T3ZZ	Destruction of Right Mandible, Percutaneous Approach
0N5V3ZZ	Destruction of Left Mandible, Percutaneous Approach
0N5X3ZZ	Destruction of Hyoid Bone, Percutaneous Approach
0P533ZZ	Destruction of Cervical Vertebra, Percutaneous Approach
Thorax	
0P503ZZ	Destruction of Sternum, Percutaneous Approach
0P513ZZ	Destruction of 1 to 2 Ribs, Percutaneous Approach
0P523ZZ	Destruction of 3 or More Ribs, Percutaneous Approach
0P593ZZ	Destruction of Right Clavicle, Percutaneous Approach
0P5B3ZZ	Destruction of Left Clavicle, Percutaneous Approach
Vertebrae and Spine	
0P543ZZ	Destruction of Thoracic Vertebra, Percutaneous Approach
0Q503ZZ	Destruction of Lumbar Vertebra, Percutaneous Approach

AngioDynamics offers this guide as basic reimbursement information. The material in this document is not intended to increase or maximize reimbursement by any payor. Laws, regulations, and payor policies concerning reimbursement are complex and change frequently. AngioDynamics recommends you consult with your payors, reimbursement specialist and/or legal counsel regarding coding, coverage, and reimbursement matters. This reimbursement data is gathered from third-party sources and does not constitute reimbursement or legal advice. AngioDynamics makes no representation or warranty regarding this information or its completeness, accuracy, timeliness, or applicability with a patient. AngioDynamics specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document. US/ON/MS/49 Rev 08 1/2023

ICD-10-PCS Code ⁹	ICD-10-PCS Description ⁹
Shoulder and Upper Arm	
0P553ZZ	Destruction of Right Scapula, Percutaneous Approach
0P563ZZ	Destruction of Left Scapula, Percutaneous Approach
0P5C3ZZ	Destruction of Right Humeral Head, Percutaneous Approach
0P5D3ZZ	Destruction of Left Humeral Head, Percutaneous Approach
0P5F3ZZ	Destruction of Right Humeral Shaft, Percutaneous Approach
0P5G3ZZ	Destruction of Left Humeral Shaft, Percutaneous Approach
0P573ZZ	Destruction of Right Glenoid Cavity, Percutaneous Approach
0P583ZZ	Destruction of Left Glenoid Cavity, Percutaneous Approach
Lower Arm and Hand	
0P5H3ZZ	Destruction of Right Radius, Percutaneous Approach
0P5J3ZZ	Destruction of Left Radius, Percutaneous Approach
0P5K3ZZ	Destruction of Right Ulna, Percutaneous Approach
0P5L3ZZ	Destruction of Left Ulna, Percutaneous Approach
0P5M3ZZ	Destruction of Right Carpal, Percutaneous Approach
0P5N3ZZ	Destruction of Left Carpal, Percutaneous Approach
0P5P3ZZ	Destruction of Right Metacarpal, Percutaneous Approach
0P5Q3ZZ	Destruction of Left Metacarpal, Percutaneous Approach
0P5R3ZZ	Destruction of Right Thumb Phalanx, Percutaneous Approach
0P5S3ZZ	Destruction of Left Thumb Phalanx, Percutaneous Approach
0P5T3ZZ	Destruction of Right Finger Phalanx, Percutaneous Approach
0P5V3ZZ	Destruction of Left Finger Phalanx, Percutaneous Approach
Pelvis, Hip and Leg	
0Q513ZZ	Destruction of Sacrum, Percutaneous Approach
0Q5S3ZZ	Destruction of Coccyx, Percutaneous Approach
0Q523ZZ	Destruction of Right Pelvic Bone, Percutaneous Approach
0Q533ZZ	Destruction of Left Pelvic Bone, Percutaneous Approach
0Q543ZZ	Destruction of Right Acetabulum, Percutaneous Approach
0Q553ZZ	Destruction of Left Acetabulum, Percutaneous Approach
0Q563ZZ	Destruction of Right Upper Femur, Percutaneous Approach
0Q573ZZ	Destruction of Left Upper Femur, Percutaneous Approach
0Q583ZZ	Destruction of Right Femoral Shaft, Percutaneous Approach
0Q593ZZ	Destruction of Left Femoral Shaft, Percutaneous Approach
0Q5B3ZZ	Destruction of Right Lower Femur, Percutaneous Approach
0Q5C3ZZ	Destruction of Left Lower Femur, Percutaneous Approach
0Q5G3ZZ	Destruction of Right Tibia, Percutaneous Approach
0Q5H3ZZ	Destruction of Left Tibia, Percutaneous Approach
0Q5J3ZZ	Destruction of Right Fibula, Percutaneous Approach
0Q5K3ZZ	Destruction of Left Fibula, Percutaneous Approach
0Q5D3ZZ	Destruction of Right Patella, Percutaneous Approach
0Q5F3ZZ	Destruction of Left Patella, Percutaneous Approach
0Q5L3ZZ	Destruction of Right Tarsal, Percutaneous Approach
0Q5M3ZZ	Destruction of Left Tarsal, Percutaneous Approach
0Q5N3ZZ	Destruction of Right Metatarsal, Percutaneous Approach
0Q5P3ZZ	Destruction of Left Metatarsal, Percutaneous Approach
0Q5Q3ZZ	Destruction of Right Toe Phalanx, Percutaneous Approach

AngioDynamics offers this guide as basic reimbursement information. The material in this document is not intended to increase or maximize reimbursement by any payor. Laws, regulations, and payor policies concerning reimbursement are complex and change frequently. AngioDynamics recommends you consult with your payors, reimbursement specialist and/or legal counsel regarding coding, coverage, and reimbursement matters. This reimbursement data is gathered from third-party sources and does not constitute reimbursement or legal advice. AngioDynamics makes no representation or warranty regarding this information or its completeness, accuracy, timeliness, or applicability with a patient. AngioDynamics specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document. US/ON/MS/49 Rev 08 1/2023

ICD-10-PCS Code ⁹	ICD-10-PCS Description ⁹
0Q5R3ZZ	Destruction of Left Toe Phalanx, Percutaneous Approach

Medicare Severity-Diagnosis Related Groups (MS-DRGs) (October 2022 - September 2023)

The following MS-DRGs may apply to bone tumor ablation procedures for Medicare patients^{10,11}. If significant additional procedures are performed during the same inpatient admission, other MS-DRGs may apply.

MS-DRG ^{10,11}	MS-DRG Description ^{10,11}	2023 Relative Weight ¹⁰	2023 Medicare Payment ¹⁰
23	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX W MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY W NEUROSTIMULATOR	5.7314	\$39,314.54
24	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.9488	\$27,086.79
25	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.5405	\$31,145.56
26	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	3.0235	\$20,739.70
27	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.4954	\$17,117.20
143	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH MCC	3.1726	21,762.45
144	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH CC	1.8093	\$12,410.89
145	OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES W/O CC	1.2078	\$8,284.90
166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.6658	\$25,145.56
167	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.9011	\$13,040.60
168	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.4176	\$9,724.03
495	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	3.7144	\$25,478.93
496	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	2.0997	\$14,402.89
497	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.5217	\$10,438.10
498	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	2.5631	\$17,581.58
499	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1.3187	\$9,045.62
503	FOOT PROCEDURES W MCC	2.5333	\$17,377.17
504	FOOT PROCEDURES W CC	1.7748	\$12,174.24
505	FOOT PROCEDURES W/O CC/MCC	1.7668	\$12,119.36
513	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.594	\$10,934.04

MS-DRG ^{10,11}	MS-DRG Description ^{10,11}	2023 Relative Weight ¹⁰	2023 Medicare Payment ¹⁰
514	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROCW/O CC/MCC	1.0327	\$7,083.81
515	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.1178	\$21,386.55
516	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	2.0338	\$13,950.85
517	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/OCC/MCC	1.5099	\$10,357.16
820	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.3176	\$36,476.08
821	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.1624	\$14,832.98
822	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.205	\$8,265.70
826	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROCW MCC	5.1419	\$35,270.86
827	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROCW CC	2.4347	\$16,700.82
828	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.7391	\$11,929.36
906	HAND PROCEDURES FOR INJURIES	1.7878	\$12,263.41
907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	3.8657	\$26,516.77
908	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.0565	\$14,106.56
909	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.3647	\$9,361.16
955	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.736	\$46,205.59
957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WMCC	7.4105	\$50,832.32
958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WCC	4.1705	\$28,607.54
959	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.5687	\$17,620.00
981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPALDIAGNOSIS W MCC	4.5804	\$31,419.25
982	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPALDIAGNOSIS W CC	2.5082	\$17,205.00
983	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPALDIAGNOSIS W/O CC/MCC	1.6702	\$11,456.74
987	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSISW MCC	3.3184	\$22,762.56
988	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.6964	\$11,636.46
989	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSISW/O CC/MCC	1.1024	\$7,561.91

AngioDynamics offers this guide as basic reimbursement information. The material in this document is not intended to increase or maximize reimbursement by any payor. Laws, regulations, and payor policies concerning reimbursement are complex and change frequently. AngioDynamics recommends you consult with your payors, reimbursement specialist and/or legal counsel regarding coding, coverage, and reimbursement matters. This reimbursement data is gathered from third-party sources and does not constitute reimbursement or legal advice. AngioDynamics makes no representation or warranty regarding this information or its completeness, accuracy, timeliness, or applicability with a patient. AngioDynamics specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document. US/ON/MS/49 Rev 08 1/2023

Other Soft Tissue Microwave & Radiofrequency Ablation

Physician, Hospital OPPTS, ASC Coding & Payment (January 2023 - December 2023)

The table of CPT® codes noted below are unlisted CPT® codes that may apply to microwave & radiofrequency ablation of other soft tissue tumors¹⁵. For other types of tumors where no such microwave or radiofrequency CPT® codes exist, an unlisted code for the anatomic area on which the procedure is performed should be reported¹⁵.

Medicare 2023 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule ³				Hospital OPPTS Payment ⁴		ASC Payment ⁵ (Payment Indicator)
CPT® Code ²	CPT® Description ²	Non-Facility		Facility		APC Code ⁴ (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
19499	Unlisted procedure, breast	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5091 (J1)	\$3,437.80	Not Covered
49999	Unlisted procedure, abdomen, peritoneum and omentum	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5301 (T)	\$825.51	Not Covered
60699	Unlisted procedure, endocrine system (for adrenal or thyroid tumors)	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5361 (J1)	\$5,212.15	Not Covered
38589	Unlisted laparoscopy procedure, lymphatic system	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5361 (J1)	\$5,212.15	Not Covered

HCPCS Codes

Healthcare Common Procedure Coding System (HCPCS) Level II codes were developed to help categorize, document, and track the use of products, supplies, and services. HCPCS codes should be reported for all device-dependent Ambulatory Payment Classifications (APCs) for procedures conducted in the hospital outpatient setting. While HCPCS codes do not generally result in additional payment, it is important for hospitals to use HCPCS codes as a means of cost reporting which CMS uses to help determine future payment rates. The HCPCS codes listed below may be used for endovenous ablation procedures.

HCPCS Code ¹²	HCPCS Description ¹²	MWA/RF System(s) Product
C1889	Implantable/insertable device, not otherwise classified	MWA/RF Ablation Probes

Reimbursement Terminology

Term	Description
APC	Ambulatory Payment Classification
APC (C)	Not paid under OPSS. Admit patient. Bill as inpatient.
APC (N)	Paid under OPSS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
APC (Q1)	Paid under OPSS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S", "T", or "V". (2) Composite APC payment if billed with specific combinations of services based on OPSS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made through a separate APC payment.
APC (Q2)	Paid under OPSS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "T". (2) In other circumstances, payment is made through a separate APC payment.
APC (J1)	Paid under OPSS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPSS status indicator of "F", "G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
APC (T)	Procedure or Service; Multiple Procedure Reduction Applies. Paid under OPSS; separate APC payment.
ASC	Ambulatory Surgery Center
APC (S)	Procedure or Service, Not Discounted When Multiple. Paid under OPSS; separate APC payment.
ASC (G2)	Non-office-based surgical procedure added in CY 2008 or later; payment based on OPSS relative payment weight
ASC (N1)	Packaged service/item; no separate payment made.
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
C-Code	Device category codes reported by hospitals in conjunction with outpatient hospital procedures
Facility	Physician payment level for professional services provided in a facility setting such as a hospital or ambulatory surgery center
Non- Facility	Physician payment level for professional services provided in a non-facility setting such as a physician's office
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
IPPS	Inpatient Prospective Payment System
MS-DRG	Medicare Severity-Diagnosis Related Group
OPSS	Outpatient Prospective Payment System
W MCC	With Major Complications and Comorbidities
W CC	With Complications and Comorbidities
W/O CC/MCC	Without complications or comorbidities, and without major complications and comorbidities.

References

1. "As currently practiced, CPT codes 32998, 47382, and 50592 should be used for both microwave and radiofrequency ablation in their respective anatomic locations in conjunction with the associated imaging guidance code (eg, 76940, 77013, or 77022). Microwave is part of the radiofrequency spectrum, and simply uses a different part of the radiofrequency spectrum to develop heat energy to destroy abnormal tissue. Microwave ablation equipment is substantially comparable to operate in practice, which is also reflected in the US Food and Drug Administration (FDA) approval of microwave devices under the 510(k) clearance process as equivalent to radiofrequency." American Medical Association (AMA) and American College of Radiology (ACR), "Clinical Examples in Radiology: A Practical Guide to Correct Coding". Volume 8, Issue 3. Summer 2012.
2. CPT © 2023 Professional. American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the AMA. No fee schedules, basic units, relative values or related listings are included in CPT® including for Category 3 codes. Inclusion of a CPT® code does not represent AMA endorsement or imply any coverage or reimbursement policy. Reimbursement information here is from the Centers for Medicare and Medicaid Services (CMS), see sources below. Applicable FARS/DFARS restrictions apply to Government Use.
3. Physician fee schedule rates were calculated using Conversion Factor (33.8872) multiplied by Total Facility & Non-Facility RVUs. CMS, CMS 1770-F: Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2023 <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-federal-regulation-notices/cms-1770-f>. Published November 2, 2022. Effective January 1, 2023. Accessed January 26, 2022.
4. CMS, CMS-1772-FC: Hospital Outpatient Prospective Payment Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1772-p>. Published November 18, 2022. Effective January 1, 2023. Accessed December 13, 2022.
5. CMS, CMS-1772-FC: Ambulatory Surgical Center Payment- Notice of Final Rulemaking with Comment Period (NFRM). <https://www.cms.gov/medicare/medicare-fee-service-payment/ascpaymentasc-regulations-and-notices/cms-1772-fc>. Published October 31, 2022. Effective January 1, 2023. Accessed December 13, 2022.
6. Use 47399 to report procedures in the liver that do not have a specific code.
7. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). 2022 release of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) . Updated October 17, 2022. Accessed December 12, 2022. <https://www.cdc.gov/nchs/icd/icd-10-cm.htm>.
8. AAPC Complete Coder, Cross-Reference "CPT® code - ICD-10-CM Crosswalk" Accessed September 13, 2021.
9. CMS, 2023 ICD-10 Procedure Coding System (ICD-10-PCS). <https://www.cms.gov/medicare/icd-10/2023-icd-10-pcs>. Accessed December 12, 2023.
10. CMS, [CMS-1771-F] 2023 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule; Federal Register. December 13, 2022. <https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page>. Payment is calculated based on the national adjusted standardized amount (\$6,859.50). Actual Medicare payment rates will vary from adjustments by Wage Index and Geographic Adjustment Factor depending on geographic locality. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.
11. AAPC. 2022 HCPCS Level II Expert: Service Supply Codes for Caregivers and Suppliers. American Academy of Professional Coders; 2021.
12. Use 53899 to report procedures in the kidney that do not have a specific code.
13. Use 32999 to report procedures in the lung that do not have a specific code.
14. CPT® guidelines instruct that you should not choose a code that merely approximates the service provided. You should report the service using only the appropriate unlisted procedure code if no such specific procedure or service code exists. You must report a Category III code when available in place of an unlisted procedure code. When reporting a procedure with an unlisted code, submit a cover letter explaining the reason for choosing the unlisted code instead of a defined, active code. Include one or more similar codes and compare your service to those codes to justify the claim amount you are billing. Also include the operative notes or other relevant documentation to strengthen the claim and to avoid a possible denial. Your payors will consider claims with unlisted procedure codes on a case-by-case basis, and they will determine payment based on the documentation you provide.



RISK INFORMATION

Indications, contraindications, warnings, and instructions for use can be found in the instructions for use supplied with each device. Observe all instructions prior to use. Failure to do so may result in patient complications. CAUTION: Federal (USA) law restricts the sale of the device by or on the order of a physician.

USA > 14 Plaza Drive, Latham, NY 12110 > tel: 800-772-6446 or 518-798-1215 > fax: 518-798-1360

International > Haaksbergweg 75 (Margrietoren), 1101 BR, Amsterdam Z-O > The Netherlands

tel: +31 (0)20 753 2949 > fax: +31 (0)20 753 2939

www.angiodynamics.com

AngioDynamics, the AngioDynamics logo, Solero, the Solero logo, StarBurst, the Starburst logo, UniBlate, the UniBlate logo are trademarks and/or registered trademarks of AngioDynamics, Inc., an affiliate or subsidiary. CPT© 2023 Professional. American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the AMA. Applicable FARS/DFARS restrictions apply to Government Use. Inclusion of a CPT® code does not represent AMA endorsement or imply any coverage or reimbursement policy. ©2022 AngioDynamics, Inc. US/ON/MS/49 Rev 08 1/2023

All other trademarks are property of their respective owners.

