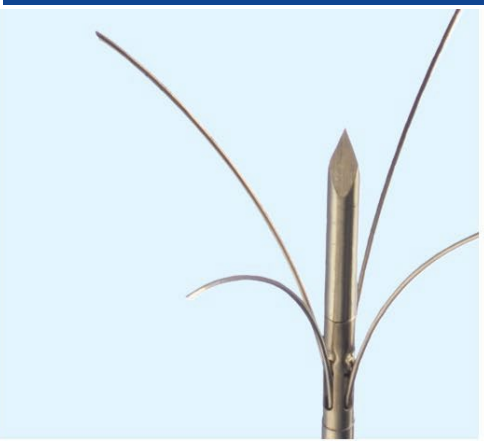
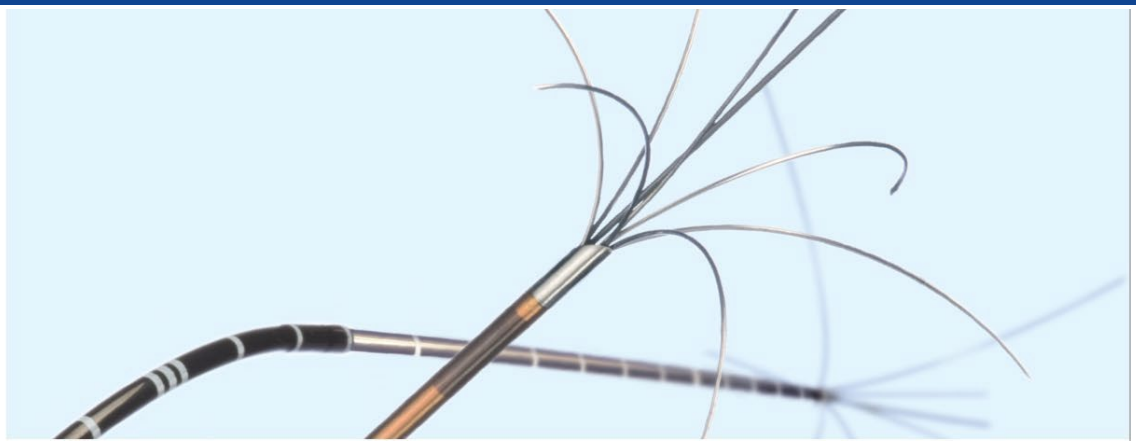
# Reimbursement Guidelines

## 2024 Microwave and Radiofrequency Ablation Reimbursement Coding Guide

## EFFECTIVE OCTOBER 1, 2023





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# Liver Microwave & Radiofrequency Ablation

## Physician, Hospital OPPS, ASC Coding & Payment (January 2024 - December 2024)

According to an American Medical Association (AMA) and American College of Radiology (ACR) co-publication[1], "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 2024 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 | 37.66 | $1,253.61 | 5362 (J1) | $9,807.76 | N/A |
| 47382 | Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency | 107.26 | $3,570.42 | 21.51 | $716.01 | 5361 (J1) | $5,497.59 | $2,705.46 (G2) |
| 77013 | Computed tomography guidance for, and monitoring of, parenchymal tissue ablation | $178.75 (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 | $195.06 (Professional Component) | | | | No APC code (N) | N/A Packaged | N/A Packaged (N1) |
| 76940 | Ultrasound guidance for, and monitoring of, parenchymal tissue ablation | $98.53 (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 | 43.38 | $1,444.01 | 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) | $670.36 | 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 2023 - September 2024)

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 indications7,8. 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 |

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 2023 - September 2024)

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] | 2024 Relative Weight[10] | 2024 Medicare Payment[10] |
|---|---|---|---|
| 356 | OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC | 4.2787 | $29,957.75 |
| 357 | OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC | 2.1968 | $15,381.11 |
| 358 | OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC | 1.2811 | $8,969.75 |
| 405 | PANCREAS, LIVER & SHUNT PROCEDURES W MCC | 5.5052 | $38,545.21 |
| 406 | PANCREAS, LIVER & SHUNT PROCEDURES W CC | 2.8874 | $20,216.42 |
| 407 | PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC | 2.1510 | $15,060.44 |

## 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, 2024 To December 31, 2024)

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 2024 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 | 34.52 | $1,149.08 | 5362 (J1) | $9,807.76 | N/A |
| 50592 | Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency | 82.56 | $2,748.22 | 10.04 | $334.21 | 5361 (J1) | $5,497.59 | $2,705.46 (G2) |
| 77013 | Computed tomography guidance for, and monitoring of, parenchymal tissue ablation | $178.75 (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 | $195.06 (Professional Component) | | | | No APC code (N) | N/A Packaged | N/A Packaged (N1) |
| 76940 | Ultrasound guidance for, and monitoring of, parenchymal tissue ablation | $98.53 (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) | $235.48 | 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 2023 - September 2024)

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 2023 - September 2024)

The listed ICD-10-PCS procedure codes are examples of codes that may apply for *kidney tumor ablation* procedures[9].

| 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 2023 - September 2024)

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

| MS-DRG[10,11] | MS-DRG Description[10,11] | 2024 Relative Weight[10] | 2024 Medicare Payment[10] |
|---|---|---|---|
| 656 | KIDNEY & URETER PROC FOR NEOPLASM W MCC | 3.1376 | $21,968.22 |
| 657 | KIDNEY & URETER PROC FOR NEOPLASM W CC | 1.8442 | $12,912.35 |
| 658 | KIDNEY & URETER PROC FOR NEOPLASM W/O CC/MCC | 1.4804 | $10,365.17 |
| 659 | KIDNEY & URETER PROC FOR NON-NEOPLASM W MCC | 2.5889 | $18,126.44 |
| 660 | KIDNEY & URETER PROC FOR NON-NEOPLASM W CC | 1.3459 | $9,423.45 |
| 661 | KIDNEY & URETER PROC FOR NON-NEOPLASM W/O CC/MCC | 1.0484 | $7,340.48 |

## 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 2024 - December 2024)

According to an American Medical Association (AMA) and American College of Radiology (ACR) co-publication[1], "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 2024 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 | 90.90 | $3,025.83 | 12.79 | $425.75 | 5361 (J1) | $5,497.59 | $2,705.46 (G2) |
| 77013 | Computed tomography guidance for, and monitoring of, parenchymal tissue ablation | $178.75 (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 | $195.06 (Professional Fee Component) | | | | No APC code (N) | N/A Packaged | N/A Packaged (N1) |
| 76940 | Ultrasound guidance for, and monitoring of, parenchymal tissue ablation | $98.53 (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) | $598.55 | 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 2023 - September 2024)

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 2023 - September 2024)

The listed ICD-10-PCS procedure codes are examples that may apply for lung tumor ablation procedures[9].

| 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 2023 - September 2024)

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] | 2024 Relative Weight[10] | 2024 Medicare Payment[10] |
|---|---|---|---|
| 163 | MAJOR CHEST PROCEDURES W MCC | 4.7136 | $33,002.74 |
| 164 | MAJOR CHEST PROCEDURES W CC | 2.5504 | $17,856.88 |
| 165 | MAJOR CHEST PROCEDURES W/O CC/MCC | 1.8764 | $13,137.80 |
| 166 | OTHER RESP SYSTEM O.R. PROCEDURES W MCC | 4.0578 | $28,411.09 |
| 167 | OTHER RESP SYSTEM O.R. PROCEDURES W CC | 1.8198 | $12,741.51 |
| 168 | OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC | 1.3557 | $9,492.07 |

# Bone Radiofrequency Ablation

## Physician, Hospital OPPS, ASC Coding & Payment (January 2024 - December 2024)

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

| Medicare 2024 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 | 102.91 | $3,425.62 | 10.82 | $360.17 | 5114 (J1) | $12,539.82 | $6,500.44 (G2) |

## ICD-10-CM Diagnosis Codes (October 2023 - September 2024)

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, andwhich 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 upperlimb | 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 |

| 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] |
|---|---|---|---|
| C40.21 | Malignant neoplasm of long bones of right lower limb | C41.4 | Malignant neoplasm of pelvic bones, sacrum andcoccyx |
| C40.22 | Malignant neoplasm of long bones of left lower limb | C41.9 | Malignant neoplasm of bone and articular cartilage,unspecified |
| 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 |
| C40.32 | Malignant neoplasm of short bones of left lowerlimb | 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 2023 - September 2024)

The listed ICD-10-PCS procedure codes are examples that may apply for bone tumor ablation procedures[9].

| 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 |

| | |
|---|---|
| **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 |
| 0Q5R3ZZ | Destruction of Left Toe Phalanx, Percutaneous Approach |

## Medicare Severity-Diagnosis Related Groups (MS-DRGs) (October 2023 - September 2024)

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] | 2024 Relative Weight[10] | 2024 Medicare Payment[10] |
|---|---|---|---|
| 23 | CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX W MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY WITH NEUROSTIMULATOR | 5.6688 | $39,690.67 |
| 24 | CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC | 3.7888 | $26,527.66 |
| 25 | CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC | 4.416 | $30,919.07 |
| 26 | CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC | 2.9531 | $20,676.42 |
| 27 | CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC | 2.4329 | $17,034.19 |
| 143 | OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH MCC | 3.3256 | $23,284.52 |
| 144 | OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES WITH CC | 1.7305 | $12,116.27 |
| 145 | OTHER EAR, NOSE, MOUTH AND THROAT O.R. PROCEDURES W/O CC | 1.2211 | $8,549.65 |
| 166 | OTHER RESP SYSTEM O.R. PROCEDURES W MCC | 4.0578 | $28,411.09 |
| 167 | OTHER RESP SYSTEM O.R. PROCEDURES W CC | 1.8198 | $12,741.51 |
| 168 | OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC | 1.3557 | $9,492.07 |
| 495 | LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC | 3.5812 | $25,074.13 |
| 496 | LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC | 1.9875 | $13,915.68 |
| 497 | LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC | 1.4274 | $9,994.08 |
| 498 | LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC | 2.611 | $18,281.18 |

| | | | |
|---|---|---|---|
| 499 | LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC | 1.2898 | $9,030.66 |
| 503 | FOOT PROCEDURES W MCC | 2.6819 | $18,777.59 |
| 504 | FOOT PROCEDURES W CC | 1.7271 | $12,092.46 |
| 505 | FOOT PROCEDURES W/O CC/MCC | 1.7057 | $11,942.63 |
| 513 | HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC | 1.621 | $11,349.59 |
| 514 | HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROCW/O CC/MCC | 1.0415 | $7,292.17 |
| 515 | OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC | 3.1615 | $22,135.56 |
| 516 | OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC | 2.0408 | $14,288.87 |
| 517 | OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/OCC/MCC | 1.4944 | $10,463.19 |
| 820 | LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC | 6.0467 | $42,336.57 |
| 821 | LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC | 2.2321 | $15,628.27 |
| 822 | LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/OCC/MCC | 1.2388 | $8,673.58 |
| 826 | MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROCW MCC | 4.3888 | $30,728.62 |
| 827 | MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROCW CC | 2.3172 | $16,224.11 |
| 828 | MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC | 1.6404 | $11,485.42 |
| 906 | HAND PROCEDURES FOR INJURIES | 1.8816 | $13,174.21 |
| 907 | OTHER O.R. PROCEDURES FOR INJURIES W MCC | 3.7195 | $26,042.45 |
| 908 | OTHER O.R. PROCEDURES FOR INJURIES W CC | 2.0041 | $14,031.91 |
| 909 | OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC | 1.3563 | $9,496.27 |
| 955 | CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA | 6.0902 | $42,641.14 |
| 957 | OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WMCC | 7.2325 | $50,639.07 |
| 958 | OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA WCC | 4.0448 | $28,320.07 |
| 959 | OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC | 2.5324 | $17,730.85 |
| 981 | EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPALDIAGNOSIS W MCC | 4.7404 | $33,190.38 |
| 982 | EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPALDIAGNOSIS W CC | 2.486 | $17,405.98 |
| 983 | EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPALDIAGNOSIS W/O CC/MCC | 1.6352 | $11,449.02 |
| 987 | NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSISW MCC | 3.3767 | $23,642.30 |
| 988 | NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC | 1.697 | $11,881.72 |
| 989 | NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSISW/O CC/MCC | 1.0803 | $7,563.83 |

# Other Soft Tissue Microwave & Radiofrequency Ablation

## Physician, Hospital OPPS, ASC Coding & Payment (January 2024 - December 2024)

The table of CPT® codes noted below are unlisted CPT® codes that may apply to microwave & radiofrequency ablationof other soft tissue tumors. 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 reported[14].

| Medicare 2024 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 | | | |
| 19499 | Unlisted procedure, breast | Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor | | | | 5091 (J1) | $3,631.79 | 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) | $863.69 | 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) | $5,497.59 | 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) | $5,497.59 | 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 OPPS. Admit patient. Bill as inpatient. |
| APC (N) | Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. |
| APC (Q1) | Paid under OPPS; Addendum B displays APC assignments when services are separately payable.<br>(1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “S”, “T”, or “V".<br>(2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services.<br>(3) In other circumstances, payment is made through a separate APC payment. |
| APC (Q2) | Paid under OPPS; Addendum B displays APC assignments when services are separately payable.<br>(1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “T”.<br>(2) In other circumstances, payment is made through a separate APC payment. |
| APC (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<br>mammography; all preventive services; and certain Part B inpatient services. |
| APC (T) | Procedure or Service; Multiple Procedure Reduction Applies. Paid under OPPS; separate APC payment. |
| ASC | Ambulatory Surgery Center |
| APC (S) | Procedure or Service, Not Discounted When Multiple. Paid under OPPS; separate APC payment. |
| ASC (G2) | Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS 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<br>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 |
| OPPS | 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 (32.7375) multiplied by Total Facility & Non-Facility RVUs. CMS, CMS 1784-F: Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2024 https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f. Published November 16, 2023. Effective January 1, 2024. Accessed November 28, 2023.
4. CMS, CMS-1786-FC: Hospital Outpatient Prospective Payment- Notice of Final Rulemaking with Comment Period (NFRM)https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc. Published November 16, 2023. Effective January 1, 2024. Accessed November 28, 2023.
5. CMS, CMS-1786-FC: Ambulatory Surgical Center Payment-Notice of Final Rulemaking with Comment Period (NFRM). https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc. Published November 16, 2023. Effective January 1, 2024. Accessed November 28, 2023.
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 June 29, 2023. Accessed November 28, 2023. 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, 2024 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/files/document/2024-official-icd-10-pcs-coding-guidelines.pdf. Accessed September 13, 2023.
10. CMS, [CMS-1785-F] 2024 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule; Federal Register. August 28, 2023. https://www.govinfo.gov/content/pkg/FR-2023-08-28/pdf/2023-16252.pdf. Payment is calculated based on the national adjusted standardized amount $7,001.60). 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.

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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.

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