



2024 NanoKnife CPT Reimbursement Guide

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2024 CPT Coding Guidelines for Ablation with IRE

CATEGORY III CPT BILLING CODES FOR PERCUTANEOUS AND OPEN IRE

The American Medical Association (AMA) CPT Editorial Panel approved two Category III CPT codes for reporting of percutaneous and open IRE ablation of tumors¹. The following Category III CPT IRE codes and average payment amounts are effective as of January 1, 2024.

Medicare 2024 National Average Payment (Not Geographically Adjusted)

Service Provided		Physician Fee Schedule ²				Hospital OPPS Payment ³		ASC Payment ⁴ (Payment Indicator)
CPT® Code ¹	CPT® Descriptor ¹	Non-Facility		Facility		APC ³ (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous (Do not report 0600T in conjunction with 76940, 77002, 77013, 77022)	No national set payment				5362 (J1)	\$9,808	\$6,604 (J8)
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open (Do not report 0601T in conjunction with 76940, 77002)	No national set payment				5362 (J1)	\$9,808	\$6,481 (J8)

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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.

HCPCS Code ⁵	HCPCS Description	Product
C1889*	Implantable/insertable device, not otherwise classified	The NanoKnife System Probes

* The MUE chart indicates that units of C1889 should be reported as 1 or 2

The IRE procedures described by the Category III CPT codes include the imaging guidance procedures, so those imaging guidance CPT codes are not separately billed on the CMS Form 1500 claim form.

Category III codes are for emerging technologies, services, and procedures. They enable physicians and outpatient facilities to report accurately and gather data on the clinical efficacy, utilization, and outcomes of emerging technologies. According to the AMA CPT, a Category III code must be used in place of an unlisted procedure code¹.

Importantly, the approval of these Category III IRE codes does not:

- Guarantee coverage by third party health payors.
- Set a national or local payment level for physician services.

In fact, payors may not immediately update their claims processing systems to include new Category III codes. Payors that have implemented the new Category III IRE codes may request documentation of clinical efficacy to support coverage. AngioDynamics can assist physicians with scientific literature and information about Medicare national coverage of the DIRECT and PRESERVE clinical trials to facilitate knowledgeable payor decision-making.

Reporting Category III codes can also initiate a dialogue between the payor and the physician on the payment level.

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PAYMENT CONSIDERATIONS

Third party health payors use different payment methodologies for Category III codes. Private payors that accept and cover Category III CPT codes can pay based on physician charges, a percentage of those charges, or if available, Medicare fee schedule amounts, as examples. Medicare/CMS does not set national physician payment levels for Category III CPT codes, so these codes are “carrier/contractor-priced”. Check with the payor to see if they have guidelines for pricing Category III codes and if so, follow those guidelines.

Physicians should be prepared to submit information to the payor that helps coverage and payment decisions. For example, CGS, a Medicare contractor, requests information that includes progress notes, documentation of previous treatments and/or clinical trials. CGS also requests an operative or procedure report as well as documentation to support medical necessity⁶. Procedures performed in an office setting may also require data about office expenses, supplies and equipment. An evidence-based dialogue with the payor contributes to accurate and equitable payment levels. Payors may describe these payment methods as crosswalking or negotiated rate setting.

Crosswalk payment from a similar procedure to the Category III code

The physician may want to offer a crosswalk analysis in communicating with a payor about a new code. The crosswalk first identifies a reference procedure with an established payment level. Next, the physician suggests that payment for the new Category III CPT IRE code should be at the same rate as the reference procedure rate because both procedures require similar physician time, effort, and complexity. The payor may accept the “comparability” of the procedures and crosswalk payment from the reference procedure to the new Category III CPT IRE code.

Medicare has used the crosswalk process in various settings⁷. While the Medicare physician fee schedule establishes payment based on the relative values of physician work, practice expenses, and malpractice, these metrics may be part of a local contractor Category III CPT code payment crosswalk. Physician work value typically focuses on:

- Time (pre-, intra-, and post-operative time in the hospital),
- Mental effort,
- Professional judgment,
- Technical skill,
- Physical effort,
- Stress due to risk, and
- Number and complexity of follow up visits.

For example, if the time, effort, and complexity of an IRE procedure is like a standard pancreatic surgical procedure, the physician may suggest to the payor that the payment for the Category III CPT IRE code should be crosswalked from the payment for the standard pancreatic surgical procedure. There may be resource similarities as well as clinical similarities because of the unique challenges of treating pancreatic cancer. Because the Category III IRE CPT codes include imaging guidance, the reference codes should also include physician resources with imaging guidance.

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Value-based Negotiated rates

Physicians may also consider a negotiated rate approach. This uses similar information from a crosswalk but with broader clinical and payment considerations, such as:

- Unique clinical value,
- Improved net health outcomes,
- Comparison of clinical impact to other treatments,
- Resource comparisons, including the relative complexity of the procedure to alternative treatment of the same condition (see discussion above on crosswalk),

- Time and professional skill to perform the procedure including pre-, intra-, and post-operative time,
- Limited number of patients who will qualify to receive the IRE treatment,
- Role of the physician in the hospital as a center of excellence.

Value-based payment can be a component of negotiated rates where the new IRE procedure offers the payor's subscribers a clinical breakthrough in treatment of a fatal disease. Since the Category III IRE CPT codes encompass the imaging guidance services, physician time and effort associated with imaging guidance should be part of the negotiated rate. Documents that payors can request include the surgical/operative note, letter of medical necessity, and for pancreatic and prostate cancers, the NanoKnife system designation as a breakthrough device, and national Medicare coverage under the DIRECT and PRESERVE clinical trials⁸. It is important to inquire if the payor has guidelines on negotiated rate setting for physician services and if so, to follow those guidelines.

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REIMBURSEMENT TERMINOLOGY

Term ⁸	Description ⁸
AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
IDE	Investigational Device Exemption
IRE	Irreversible Electroporation (Procedure performed with the NanoKnife System)
LCD	Local Coverage Determination
NCD	National Coverage Determination
OPPS	Outpatient Prospective Payment System
RBRVS	Resource Based Relative Value Scale
RVU	Relative Value Unit

OTHER RESOURCES

For NanoKnife System inpatient hospital-related reimbursement information, please refer to the [NanoKnife Inpatient Hospital Reimbursement Guide](#).

For other reimbursement educational materials, guides, and resources, please visit: [Reimbursement Resources](#) website.

For information about **DIRECT**, a clinical study for stage III pancreatic cancer sponsored by AngioDynamics, Inc., please visit the [DIRECT Study](#) website. This comprehensive clinical study will evaluate the effects of irreversible electroporation (IRE) ablation technology on the treatment of stage III pancreatic cancer.

For information about **PRESERVE**, a pivotal study of the NanoKnife System for ablation of prostate tissue sponsored by AngioDynamics, Inc., please visit the [PRESERVE Study](#) website. This clinical study assesses the safety and effectiveness of IRE when used to ablate prostate tissue in intermediate-risk prostate cancer patients.

REIMBURSEMENT SUPPORT

For questions regarding coding, payment, coverage, and other reimbursement information, please contact us at: Reimbursement@angiodynamics.com

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REFERENCES

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2. Physician fee schedule rates were calculated using Conversion Factor (32.7375) multiplied by Total Facility & Non-Facility RVUs. CMS, CMS 1784-F: Medicare and Medicaid Programs; CY2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program <https://public-inspection.federalregister.gov/2023-24184.pdf>. Published November 16, 2023. Effective January 1, 2024. Accessed December 4, 2023.
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7. See references to crosswalk at 84 Federal Register 62570 (November 15, 2019), and 75 Federal Register 73,183 (for practice expenses) 73328 – 73329 for physician work and addressing the AMA RUC valuation process. (November 29, 2010). The AMA RUC does not conduct surveys, calculate values, or make payment recommendations on Category III codes. Note that Medicare does not now use a conventional cross walk under the RBRVS system for national rate setting, but local Medicare contractors and private payors recognize crosswalk as an appropriate way to price new codes.
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Indication For Use

US: The NanoKnife System with six outputs is indicated for surgical ablation of soft tissue.

Contraindications

Ablation procedures using the NanoKnife System are contraindicated in the following cases: • Ablation of lesions in the thoracic area in the presence of implanted cardiac pacemakers or defibrillators • Ablation of lesions in the vicinity of implanted electronic devices or implanted devices with metal parts • Ablation of lesions of the eyes, including the eyelids • Patient history of Epilepsy or Cardiac Arrhythmia • Recent history of Myocardial Infarction

Potential Adverse Effects

Adverse effects that may be associated with the use of the NanoKnife system include, but are not limited to,

the following: • Arrhythmia • Atrial fibrillation or flutter • Bigeminy • Bradycardia • Heart block or atrioventricularblock • Paroxysmal supraventricular tachycardia • Tachycardia • Reflex tachycardia • Ventricular tachycardia • Ventricular fibrillation • Damage to critical anatomical structure (nerve, vessel, and/or duct) • Fistula formation • Hematoma • Hemorrhage • Hemothorax • Infection • Pneumothorax • Reflex Hypertension • Unintended mechanical perforation • Vagal Stimulation, asystole • Venous Thrombosis

Refer to Directions for Use and/or User Manual provided with the product for complete Instructions, Warnings, Precautions, Possible Adverse Effects and Contraindications. Observe all instructions for use prior to use. Failure to do so may result in patient complications. CAUTION: Federal Law (USA) restricts this device to sale by or on the order of a physician.



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