

2022 Reimbursement Guide

Microwave Ablation of Soft Tissue Lesions

Medicare National Average Outpatient Hospital, Ambulatory Surgical Center (ASC) and Physician Codes and Payment for Microwave Ablation

Ambulatory Payment Classifications (APCs) are Medicare outpatient hospital payment groupings which are determined by the CPT® code submitted by the hospital. All payment rates are Medicare National Average payments. Listed CPT codes may be appropriate to describe surgical procedures or imaging/guidance procedures associated with **microwave ablation of soft tissue lesions**.

CPT® Code ¹	Description	Hospital		Physician		Copay
		Outpatient Medicare National Average Payment CY2022 ² /APC	ASC Medicare National Average Payment CY2022 ²	Physician Medicare National Average Payment CY2022 ² Facility ⁴ /RVU ³	Physician Medicare National Average Payment CY2022 ² Non-Facility ⁴ /RVU ³	Minimum Copay
LIVER						
47000	Biopsy of liver, needle, percutaneous	\$1,436.99 / 5072	\$608.63	\$88.25 / 2.55	\$318.03 / 9.19	\$287.40
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	\$9,096.46 / 5362	N/A	\$1,291.16 / 37.31	N/A	\$1,819.30
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	Inpatient Only	N/A	\$1,490.84 / 43.08	N/A	N/A
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	\$5,167.69 / 5361	\$2,363.27	\$739.19 / 21.36	\$3,954.10 / 114.26	\$1,033.54
LUNG						
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, radiofrequency, unilateral	\$5,167.69 / 5361	\$2,363.27	\$439.50 / 12.70	\$3,356.46 / 96.99	\$1,033.54
KIDNEY						
50200	Needle biopsy of kidney	\$1,436.99 / 5072	\$608.63	\$128.04 / 3.70	\$551.28 / 15.93	\$287.40
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	\$9,096.46 / 5362	N/A	\$1,179.38 / 34.08	N/A	\$1,819.30
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	\$5,167.69 / 5361	\$2,363.27	\$344.33 / 9.95	\$3,061.61 / 88.47	\$1,033.54

CPT® Code ¹	Description	Hospital		Physician		Copay
		Outpatient Medicare National Average Payment CY2022 ² /APC	ASC Medicare National Average Payment CY2022 ²	Physician Medicare National Average Payment CY2022 ² Facility ⁴ /RVU ³	Physician Medicare National Average Payment CY2022 ² Non-Facility ⁴ /RVU ³	Minimum Copay
ALL SOFT TISSUE LESIONS						
71250	Computed tomography, thorax; without contrast material	\$111.19 / 5522	\$56.39	\$52.60 / 1.52	\$52.60 / 1.52	\$22.24
71260	Computed tomography, thorax; with contrast material(s)	\$182.43 / 5571	\$92.51	\$56.41 / 1.63	\$56.41 / 1.63	\$36.49
71270	Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections	\$182.43 / 5571	\$92.51	\$61.25 / 1.77	\$61.25 / 1.77	\$36.39
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	Status Indicator N1: Packaged item or service	Status Indicator N1: Packaged item or service	\$101.40 / 2.93	\$101.40 / 2.93	N/A
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	Status Indicator N1: Packaged item or service	Status Indicator N1: Packaged item or service	\$185.14 / 5.35	\$185.14 / 5.35	N/A
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	Status Indicator N1: Packaged item or service	Status Indicator N1: Packaged item or service	\$205.91 / 5.95	\$205.91 / 5.94	N/A

NOTE: For outpatient hospital services, **HCPCS Level II Code C1886** (Catheter, extravascular tissue ablation, any modality {insertable}) may be used to report the ablation catheter used, however, the **Medicare payment for the catheter is packaged into the APC and ASC procedure payments** effective January 1, 2014. Private payer policies may differ. Providers should check with their local payers to determine the applicable reporting and reimbursement policies.

Medicare National Average Inpatient Payment for Microwave Ablation, Effective through September 30, 2022

MS-DRG assignment is based on ICD-10 procedure and diagnosis codes. The following tables provide the ICD-10 codes as well as the MS-DRGs to which microwave ablation may be assigned.

Possible ICD-10 Procedure Codes

LIVER	
OF500ZZ	Destruction of Liver, Open Approach
OF510ZZ	Destruction of Right Lobe Liver, Open Approach
OF520ZZ	Destruction of Left Lobe Liver, Open Approach
OF503ZZ	Destruction of Liver, Percutaneous Approach
OF513ZZ	Destruction of Right Lobe Liver, Percutaneous Approach
OF523ZZ	Destruction of Left Lobe Liver, Percutaneous Approach
OF504ZZ	Destruction of Liver, Percutaneous Endoscopic Approach
OF514ZZ	Destruction of Right Lobe Liver, Percutaneous Endoscopic Approach
OF524ZZ	Destruction of Left Lobe Liver, Percutaneous Endoscopic Approach

Possible ICD-10 Procedure Codes *cont...*

LUNG	
OB5COZZ	Destruction of Right Upper Lung Lobe, Open Approach
OB5DOZZ	Destruction of Right Middle Lung Lobe, Open Approach
OB5FOZZ	Destruction of Right Lower Lung Lobe, Open Approach
OB5GOZZ	Destruction of Left Upper Lung Lobe, Open Approach
OB5HOZZ	Destruction of Lung Lingula, Open Approach
OB5JOZZ	Destruction of Left Lower Lung Lobe, Open Approach
OB5KOZZ	Destruction of Right Lung, Open Approach
OB5LOZZ	Destruction of Left Lung, Open Approach
OB5MOZZ	Destruction of Bilateral Lungs, Open Approach
OB5C3ZZ	Destruction of Right Upper Lung Lobe, Percutaneous Approach
OB5D3ZZ	Destruction of Right Middle Lung Lobe, Percutaneous Approach
OB5F3ZZ	Destruction of Right Lower Lung Lobe, Percutaneous Approach
OB5G3ZZ	Destruction of Left Upper Lung Lobe, Percutaneous Approach
OB5H3ZZ	Destruction of Lung Lingula, Percutaneous Approach
OB5J3ZZ	Destruction of Left Lower Lung Lobe, Percutaneous Approach
OB5K3ZZ	Destruction of Right Lung, Percutaneous Approach
OB5L3ZZ	Destruction of Left Lung, Percutaneous Approach
OB5M3ZZ	Destruction of Bilateral Lungs, Percutaneous Approach
OB5C4ZZ	Destruction of Right Upper Lung Lobe, Percutaneous Endoscopic Approach
OB5D4ZZ	Destruction of Right Middle Lung Lobe, Percutaneous Endoscopic Approach
OB5F4ZZ	Destruction of Right Lower Lung Lobe, Percutaneous Endoscopic Approach
OB5G4ZZ	Destruction of Left Upper Lung Lobe, Percutaneous Endoscopic Approach
OB5H4ZZ	Destruction of Lung Lingula, Percutaneous Endoscopic Approach
OB5J4ZZ	Destruction of Left Lower Lung Lobe, Percutaneous Endoscopic Approach
OB5K4ZZ	Destruction of Right Lung, Percutaneous Endoscopic Approach
OB5L4ZZ	Destruction of Left Lung, Percutaneous Endoscopic Approach
OB5M4ZZ	Destruction of Bilateral Lungs, Percutaneous Endoscopic Approach
KIDNEY	
OT500ZZ	Destruction of Right Kidney, Open Approach
OT510ZZ	Destruction of Left Kidney, Open Approach
OT530ZZ	Destruction of Right Kidney Pelvis, Open Approach
OT540ZZ	Destruction of Left Kidney Pelvis, Open Approach
OT503ZZ	Destruction of Right Kidney, Percutaneous Approach
OT513ZZ	Destruction of Left Kidney, Percutaneous Approach
OT533ZZ	Destruction of Right Kidney Pelvis, Percutaneous Approach
OT543ZZ	Destruction of Left Kidney Pelvis, Percutaneous Approach
OT504ZZ	Destruction of Right Kidney, Percutaneous Endoscopic Approach
OT514ZZ	Destruction of Left Kidney, Percutaneous Endoscopic Approach
OT534ZZ	Destruction of Right Kidney Pelvis, Percutaneous Endoscopic Approach
OT544ZZ	Destruction of Left Kidney Pelvis, Percutaneous Endoscopic Approach

MS-DRG	Description	Medicare National Average Inpatient Payment FY2022⁵
LIVER		
356	Other digestive system O.R. procedures with MCC	\$28,407
357	Other digestive system O.R. procedures with CC	\$14,959
358	Other digestive system O.R. procedures without CC/MCC	\$8,896
405	Pancreas, liver and shunt procedure with MCC	\$37,836
406	Pancreas, liver and shunt procedures with CC	\$18,998
407	Pancreas, liver and shunt procedures without CC/MCC	\$13,967
LUNG		
163	Major chest procedure with MCC	\$33,016
164	Major chest procedure with CC	\$17,512
165	Major chest procedure without CC/MCC	\$12,639
166	Other resp system O.R. procedures with MCC	\$24,554
167	Other resp system O.R. procedures with CC	\$11,993
168	Other resp system O.R. procedures without CC/MCC	\$8,931
KIDNEY		
656	Kidney and ureter procedures for neoplasm with MCC	\$21,662
657	Kidney and ureter procedures for neoplasm with CC	\$12,758
658	Kidney and ureter procedures for neoplasm without CC/MCC	\$10,405

MC: Major complications and/or comorbidities

CC: Complications and/or comorbidities

- ¹ 2022 Current Procedural Terminology (CPT®) Professional Edition. CPT is a registered trademark of the American Medical Association. All rights reserved.
- ² CMS-1753-FC Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, final rule CY2022. Effective through December 31, 2022.
- ³ CMS-1751-F Physician Fee Schedule final rule CY2022. Effective through December 31, 2022. Conversion factor of \$34.6062.
- ⁴ 'Facility' - Procedure done in a facility other than the physician's office. 'Non-Facility' - Physician's office.
- ⁵ CMS-1752-F Hospital Inpatient Prospective Payment System final rule FY2022, effective through September 30, 2022

NOTES:

CPT procedure codes for guidance are subject to National Correct Coding Initiative Edits (NCCI edits). NCCI edits focus on pairs of codes that are not separately payable, except under certain circumstances permissible with a modifier. We urge providers to always review NCCI edits previous to billing procedural codes. NCCI edits are available online at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodingEd/>

According to a 2012 American Medical Association publication (Clinical Examples in Radiology, Vol. 8, Issue 3; Summer 2012), "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, they instruct that microwave ablation should be reported using the CPT codes for radiofrequency ablation. If there is not a specific CPT code for ablation, the unlisted CPT code for the anatomic area should be reported.

INDICATIONS FOR USE:

The NeuWave Medical Certus 140™ 2.45 GHz Ablation System and Accessories are indicated for the ablation (coagulation) of soft tissue in percutaneous, open surgical and in conjunction with laparoscopic surgical settings, including the partial or complete ablation of non-resectable liver tumors. The Certus 140™ 2.45 GHz Ablation System is not indicated for use in cardiac procedures. The system is designed for facility use and should only be used under the orders of a clinician."

DISCLAIMER:

The information in this guide is broad-based and references many different procedures and types of devices. Such a broad discussion is not intended to suggest or imply that NeuWave offers products for every use or procedure discussed and the FDA-cleared or approved labeling for all products may not be consistent with the information in this guide. As always, please refer to the product's instructions for use or package insert for a complete description of indications and contraindications for any medical device type mentioned in these materials prior to use.

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