2020 Reimbursement Guide

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. The Ambulatory Surgical Center (ASC) rates are Medicare National Average. Listed CPT codes may be appropriate to describe surgical procedures or imaging/guidance procedures associated with microwave ablation of soft tissue lesions.

		Hospital		Physician		Copay
CPT® Code[1]	Description	Outpatient Medicare National Average Payment CY2020[2]/APC	ASC Medicare National Average Payment CY2020[2]	Physician Medicare National Average Payment CY2020[2] Facility[4]/RVU[3]	Physician Medicare National Average Payment CY2020[2] Non-Facility[4]/RVU[3]	Minimum Copay
LIVER						
47000	Biopsy of liver, needle, percutaneous	$1,372.45 / 5072	$576.39	$92.39 / 2.56	$319.39 / 8.85	$274.49
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	$8,412.18 / 5362	N/A	$1,314.02 / 36.41	N/A	$1,682.44
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	Inpatient Only	N/A	$1,519.73 / 42.11	N/A	N/A
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	$4,833.17 / 5361	$2,194.07	$775.20 / 21.48	$4522.03 / 125.30	$966.64
74150	Computed tomography, abdomen; without contrast material	$112.07 / 5522	$56.63	$60.99 / 1.69	$60.99 / 1.69	$22.42
74160	Computed tomography, abdomen; with contrast material(s)	$182.20 / 5571	$92.08	$65.32 / 1.81	$65.32 / 1.81	$36.44
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	$182.20 / 5571	$92.08	$71.82 / 1.99	$71.82 / 1.100	$36.44
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	$4,833.17 / 5361	$2,194.07	$460.86 / 12.77	$3,593.44 / 99.57	$966.64
71250	Computed tomography, thorax; without contrast material	$112.07 / 5522	$56.63	$59.19 / 1.64	$59.19 / 1.65	$22.42
71260	Computed tomography, thorax; with contrast material(s)	$182.20 / 5571	$92.08	$63.88 / 1.77	$63.88 / 1.78	$36.44
71270	Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections	$182.20 / 5571	$92.08	$70.37 / 1.95	$70.37 / 1.96	$36.44

		Hospital		Physician		Copay
CPT® Code[1]	Description	Outpatient Medicare National Average Payment CY2020[2]/APC	ASC Medicare National Average Payment CY2020[2]	Physician Medicare National Average Payment CY2020[2] Facility[4]/RVU[3]	Physician Medicare National Average Payment CY2020[2] Non-Facility[4]/RVU[3]	Minimum Copay
KIDNEY						
50200	Needle biopsy of kidney	$1,372.45 / 5072	$576.39	$133.53 / 3.70	$558.31 / 15.47	$274.49
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	$8,412.18 / 5362	N/A	$1,214.78 / 33.66	N/A	$1,682.44
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	$4,833.17 / 5361	$2,194.07	$358.01 / 9.92	$3,291.01 / 91.19	$966.64
74150	Computed tomography, abdomen; without contrast material	$112.07 / 5522	$56.63	$60.99 / 1.69	$60.99 / 1.69	$22.42
74160	Computed tomography, abdomen; with contrast material(s)	$182.20 / 5571	$92.08	$65.32 / 1.81	$65.32 / 1.81	$36.44
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	$182.20 / 5571	$92.08	$71.82 / 1.99	$71.82 / 1.100	$36.44
ALL SOFT TISSUE LESIONS						
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	**Status Indicator N:** Packaged item or service	**Status Indicator N:** Packaged item or service	$105.74 / 2.93	$105.74 / 2.94	N/A
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	**Status Indicator N:** Packaged item or service	**Status Indicator N:** Packaged item or service	$195.61 / 5.42	$195.61 / 5.43	N/A
77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	**Status Indicator N:** Packaged item or service	**Status Indicator N:** Packaged item or service	$220.87 / 6.12	$220.87 / 6.13	N/A

Medicare National Average Inpatient Payment for Microwave Ablation, Effective Through September 30, 2020

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	
0F500ZZ	Destruction of Liver, Open Approach
0F510ZZ	Destruction of Right Lobe Liver, Open Approach
0F520ZZ	Destruction of Left Lobe Liver, Open Approach
0F503ZZ	Destruction of Liver, Percutaneous Approach
0F513ZZ	Destruction of Right Lobe Liver, Percutaneous Approach
0F523ZZ	Destruction of Left Lobe Liver, Percutaneous Approach
0F504ZZ	Destruction of Liver, Percutaneous Endoscopic Approach
0F514ZZ	Destruction of Right Lobe Liver, Percutaneous Endoscopic Approach
0F524ZZ	Destruction of Left Lobe Liver, Percutaneous Endoscopic Approach

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

LUNG	
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
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
0B5C4ZZ	Destruction of Right Upper Lung Lobe, Percutaneous Endoscopic Approach
0B5D4ZZ	Destruction of Right Middle Lung Lobe, Percutaneous Endoscopic Approach
0B5F4ZZ	Destruction of Right Lower Lung Lobe, Percutaneous Endoscopic Approach
0B5G4ZZ	Destruction of Left Upper Lung Lobe, Percutaneous Endoscopic Approach
0B5H4ZZ	Destruction of Lung Lingula, Percutaneous Endoscopic Approach
0B5J4ZZ	Destruction of Left Lower Lung Lobe, Percutaneous Endoscopic Approach
0B5K4ZZ	Destruction of Right Lung, Percutaneous Endoscopic Approach
0B5L4ZZ	Destruction of Left Lung, Percutaneous Endoscopic Approach
0B5M4ZZ	Destruction of Bilateral Lungs, Percutaneous Endoscopic Approach
KIDNEY	
0T500ZZ	Destruction of Right Kidney, Open Approach
0T510ZZ	Destruction of Left Kidney, Open Approach
0T530ZZ	Destruction of Right Kidney Pelvis, Open Approach
0T540ZZ	Destruction of Left Kidney Pelvis, Open Approach
0T503ZZ	Destruction of Right Kidney, Percutaneous Approach
0T513ZZ	Destruction of Left Kidney, Percutaneous Approach
0T533ZZ	Destruction of Right Kidney Pelvis, Percutaneous Approach
0T543ZZ	Destruction of Left Kidney Pelvis, Percutaneous Approach
0T504ZZ	Destruction of Right Kidney, Percutaneous Endoscopic Approach
0T514ZZ	Destruction of Left Kidney, Percutaneous Endoscopic Approach
0T534ZZ	Destruction of Right Kidney Pelvis, Percutaneous Endoscopic Approach
0T544ZZ	Destruction of Left Kidney Pelvis, Percutaneous Endoscopic Approach

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MS-DRG	Description	Medicare National Average Inpatient Payment FY2020[5]
LIVER		
356	Other digestive system O.R. procedures with MCC	$25,538.52
357	Other digestive system O.R. procedures with CC	$14,095.92
358	Other digestive system O.R. procedures without CC/MCC	$8,591.35
405	Pancreas, liver and shunt procedure with MCC	$33,994.57
406	Pancreas, liver and shunt procedures with CC	$17,481.47
407	Pancreas, liver and shunt procedures without CC/MCC	$13,068.04
LUNG		
163	Major chest procedure with MCC	$30,527.59
164	Major chest procedure with CC	$15,857.28
165	Major chest procedure without CC/MCC	$11,582.91
166	Other resp system O.R. procedures with MCC	$23,368.13
167	Other resp system O.R. procedures with CC	$11,991.30
168	Other resp system O.R. procedures without CC/MCC	$8,310.10
KIDNEY		
656	Kidney and ureter procedures for neoplasm with MCC	$20,423.55
657	Kidney and ureter procedures for neoplasm with CC	$12,115.33
658	Kidney and ureter procedures for neoplasm without CC/MCC	$9,833.45

MC: Major complications and/or comorbidities

CC: Complications and/or comorbidities

[1] 2019 Current Procedural Terminology (CPT®) Professional Edition. CPT is a registered trademark of the American Medical Association. All rights reserved.
[2] CMS-1695-FC Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, final rule CY2019. Effective through December 31, 2019.
[3] CMS-1693-F Physician Fee Schedule final rule CY2019. Effective through December 31, 2019.
[4] 'Facility' – Procedure done in a facility other than the physician's office. 'Non-Facility' – Physician's office.
[5] CMS-1694-F & CMS-1694-CN2 Inpatient Prospective Payment System final rule FY2019, effective through September 30, 2019.

NOTES:
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 device 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.

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/NationalCorrectCodInitEd/

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.

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