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CRYOABLATION

2024 Billing and Coding Guide

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Commonly billed scenarios

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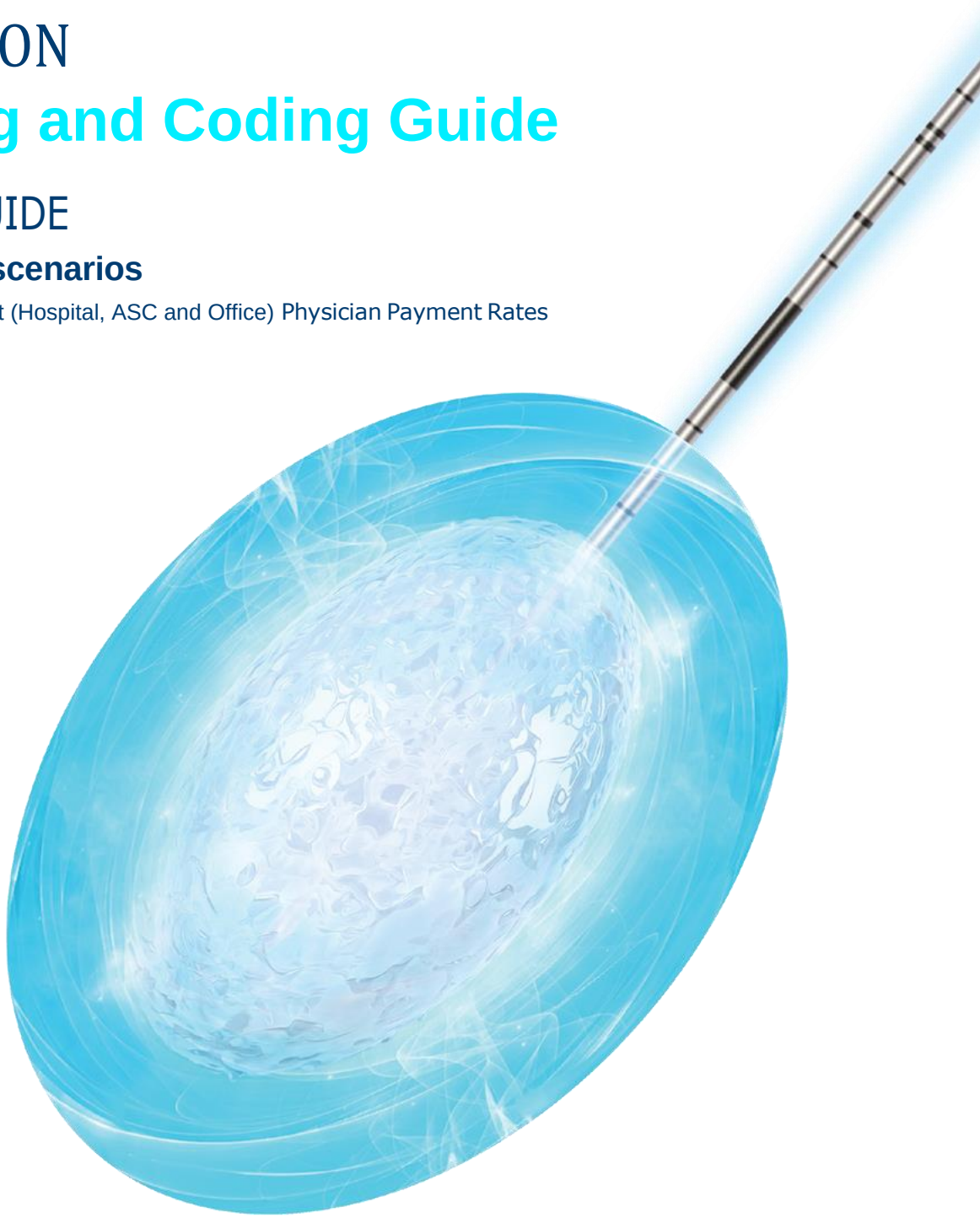

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ICEfx™ Cryoablation System, Visual Ice™ Cryoablation System, Visual Ice™ MRI Cryoablation System, and Needles (IceSeed™, IceSphere™, IceRod™, IceForce™, IcePearl™)

2024 BILLING & CODING GUIDE WITH MEDICARE ALLOWABLE REIMBURSEMENT

ABOUT CRYOABLATION

The ICEfx, Visual Ice, and Visual Ice MRI Cryoablation Systems are intended for cryoablative destruction of tissue during minimally invasive procedures; various accessory products are required to perform these procedures. These cryoablation systems are indicated for use as a cryosurgical tool in the fields of general surgery, dermatology, neurology (including cryoanalgesia), thoracic surgery (with the exception of cardiac tissue), ENT, gynecology, oncology, proctology, and urology. These systems are designed to destroy tissue (including prostate and kidney tissue, liver metastases, tumors, and skin lesions) by the application of extremely cold temperatures. The ICEfx, Visual Ice, and Visual Ice MRI Cryoablation Systems have the following specific indications:

- Urology Ablation of prostate tissue in cases of prostate cancer and Benign Prostate Hyperplasia (BPH)
- Oncology Ablation of cancerous or malignant tissue and benign tumors, and palliative intervention
- Dermatology Ablation or freezing of skin cancers and other cutaneous disorders. Destruction of warts or lesions, angiomas, sebaceous hyperplasia, basal cell tumors of the eyelid or canthus area, ulcerated basal cell tumors, dermatofibromas, small hemangiomas, mucocele cysts, multiple warts, plantar warts, actinic and seborrheic keratosis, cavernous hemangiomas, peri-anal condylomata, and palliation of tumors of the skin
- Gynecology Ablation of malignant neoplasia or benign dysplasia of the female genitalia
- General Surgery palliation of tumors of the rectum, anal fissures, pilonidal cysts, and recurrent cancerous lesions, ablation of breast fibroadenomas
- ENT palliation of tumors of the oral cavity and ablation of leukoplakia of the mouth
- Thoracic Surgery (with the exception of cardiac tissue)
- Proctology Ablation of benign or malignant growths of the anus or rectum

CONTRAINDICATIONS

There are no known contraindications specific to the use of the ICEfx, Visual Ice, and Visual Ice MRI Cryoablation Systems.

Caution: Federal law restricts this device to sale by or on the order of a physician. Additional important safety information about the above products is available at the following website: https://www.bostonscientific.com/content/gwc/en-US/products/cryoablation.html.

Please review the website if you intend to use these products.
These products may only be used by licensed healthcare professionals.

See important notes on the uses and limitations of this information on page 4.

Claims must contain the appropriate HCPCS/CPT/ICD-10 code(s) for the specific site of service to indicate the items and services that are furnished. The tables below contain a list of possible HCPCS/CPT/ICD-10 codes that may be used to bill for Cryoablation. Providers should select the most appropriate code(s) and modifier(s) with the highest level of detail to describe the service(s) actually rendered. CPT ® Copyright 2023 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

IMPORTANT INFORMATION

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. **It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered**. It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters.

Boston Scientific does not promote the use of its products outside its FDA-approved label. Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. All trademarks are the property of their respective owners.

This coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgment of the HCP.

DEVICE CODING

Each cryoablation needle is coded as HCPCS C2618 – Probe/needle, cryoablation. Reimbursement for the cryoablation needle is included in the procedural payment. Coding for the procedure is specific to the anatomical region or organ. Procedures performed laparoscopically or as an open surgical procedure are coded as ablation without reference as to type.

The Revenue Code suggested by Medicare is 0278 – Other Implants.
Department of Health and Human Services, CMS 42 CFR Parts 410, 416, and 419 [CMS-1414-FC] RIN 0938-AP41

See important notes on the uses and limitations of this information on page 4.

INTERVENTIONAL ONCOLOGY (IO) ABLATION REIMBURSEMENT SUPPORT

Boston Scientific has contracted with The Pinnacle Health Group to provide assistance with coding, coverage, and payment activities related to Interventional Oncology (IO) Ablation treatment, to include:

General Reimbursement Support

- Support providers with coding options and tools to reference coding for IO ablation and related procedures
- Provide current coverage policy information for IO Ablation procedures
- Review inadequate reimbursement or denials
- Support patient information requests

Benefit Verification and Prior Authorization Support

- Support providers with prior authorization for IO ablation procedures
- Support prior authorization requests and appeals
- Provide appropriate documentation for benefit verification, prior authorization and predetermination

Prior Authorization and Claim Appeals

- Support physicians and patients with the appeal process
- Assist with appeal letters and documentation necessary to approach payers with appropriate coverage requests
- Coordinate appeals through permitted appeal steps and peer to peer reviews
- Follow up with payers regarding requests on a scheduled basis

The Pinnacle Health Group team is available weekdays from 8:30 am - 6:00 pm EST at (215) 369-9290 or IOAblation@thepinnaclehealthgroup.com.

See important notes on the uses and limitations of this information on page 4.

Percutaneous Cryoablation - Renal

PHYSICIAN SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Physician Fee Schedule		
CPT® Code	CPT® Description	RVUs	Facility	Non Facility
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	8.88	$446	$3,675
76940	Ultrasound monitoring parenchymal tissue ablation	0.00	$99	$99
77013	CT monitoring parenchymal tissue ablation	0.00	$179	$179
77022	MR monitoring parenchymal tissue ablation	0.00	$195	$195
50200	Renal biopsy; percutaneous, by trocar or needle	2.38	$124	$506
76942	Ultrasonic guidance for needle placement, IS&I	0.67	$30	$58
77012	CT guidance for needle placement, IS&I	1.50	$68	$139
77021	MR guidance for needle placement, IS&I	1.50	$70	$425

CPT Codes are used to report medical services and procedures performed by or under the direction of physicians in the office or facility setting. The MPFS is based on Relative Value Units (RVUs) assigned to each CPT code. RVUs represent the physician's work, practice expenses and malpractice costs associated with each procedure or service. Reimbursement for commercial payers may be based on the Medicare RVUs or by a contractually negotiated rate.

OPPS/ASC PROCEDURAL SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Hospital Outpatient	ASC
APC	APC Description	Payment	Payment
5362	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy (CPT 50593)	$9,818	$6,432
5072	Renal biopsy; percutaneous, by trocar or needle (CPT 50200)	$1,546	$683

HCPCS SUPPLY ITEM REPORTING

Service Provided		Hospital Outpatient	ASC
C-Code	Description	Payment	Payment
C2618*	Probe/needle, cryoablation	Packaged	Packaged

*Must be billed per unit used.

INPATIENT DIAGNOSIS RELATED GROUPS # FY 2024 (10/01/2023-09/30/2024)

Service Provided		Hospital Inpatient
MS-DRG	Description	Payment
656	Kidney & ureter procedures for neoplasm w/MCC	$23,185
657	Kidney & ureter procedures for neoplasm w/CC	$13,010
658	Kidney & ureter procedures for neoplasm w/o CC/MCC	$10,703

See important notes on the uses and limitations of this information on page 4.

ICD-10 Codes

Percutaneous Cryoablation - Renal

ICD-10-CM*	ICD-10-CM Descriptor	ICD-10-PCS	ICD-10-PCS Descriptor
C64.-	Malignant neoplasm of kidney, except renal pelvis	0T5_3ZZ	Destruction of Kidney or Kidney Pelvis, Percutaneous Approach
C65.-	Malignant neoplasm of renal pelvis		
C79.0-	Secondary malignant neoplasm kidney and renal pelvis		
C7A.093	Malignant carcinoid tumor of the kidney		
C80.2	Malignant neoplasm associated with transplanted organ		
D09.10	Carcinoma in situ of unspecified urinary organ		
D09.19	Carcinoma in situ of other urinary organs		
D30.0-	Benign neoplasm of kidney		
D30.1-	Benign neoplasm of renal pelvis		
D3A.093	Benign carcinoid tumor of the kidney		
D41.0-	Neoplasm of uncertain behavior of kidney		
D41.1-	Neoplasm of uncertain behavior renal pelvis		
D41.2-	Neoplasm of uncertain behavior of ureter		
D49.51-	Neoplasm of unspecified behavior of kidney		
D49.59	Neoplasm of unspecified behavior of other genitourinary organ		

* - indicates more specified coding may be required
_ indicates a value is needed to complete code

Disclaimer

The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting relevant manuals for appropriate coding options.

See important notes on the uses and limitations of this information on page 4.

Cryoablation - Percutaneous LUNG

PHYSICIAN SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Physician Fee Schedule		
CPT® Code	CPT® Description	RVUs	Facility	Non Facility
32994	Percutaneous pulmonary cryoablation, 1 or > tumor(s), unilateral; including imaging guidance/monitoring	9.03	$425	$4,739
32408	Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed	3.18	$148	$838
76942	Ultrasonic guidance for needle placement, IS&I	0.67	$30	$58
77012	CT guidance for needle placement, IS&I	1.50	$68	$139
77021	MR guidance for needle placement, IS&I	1.50	$70	$425

CPT Codes are used to report medical services and procedures performed by or under the direction of physicians in the office or facility setting. The MPFS is based on Relative Value Units (RVUs) assigned to each CPT code. RVUs represent the physician's work, practice expenses and malpractice costs associated with each procedure or service. Reimbursement for commercial payers may be based on the Medicare RVUs or by a contractually negotiated rate.

OPPS/ASC PROCEDURAL SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Hospital Outpatient	ASC
APC	APC Description	Payment	Payment
5361	Percutaneous pulmonary cryoablation, 1 or > tumor(s), unilateral; including imaging guidance/monitoring (CPT 32994)	$5,503	$6,126
5072	Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed (CPT 32408)	$1,546	$683

HCPCS SUPPLY ITEM REPORTING

Service Provided		Hospital Outpatient	ASC
C-Code	Description	Payment	Payment
C2618*	Probe/needle, cryoablation	Packaged	Packaged

*Must be billed per unit used.

INPATIENT DIAGNOSIS RELATED GROUPS # FY 2024 (10/01/2023-09/30/2024)

Service Provided		Hospital Inpatient
MS-DRG	Description	Payment
163	Major chest procedures w/MCC	$32,802
164	Major chest procedure w/CC	$17,912
165	Major chest procedures w/o CC/MCC	$13,265

See important notes on the uses and limitations of this information on page 4.

ICD-10 Codes

Cryoablation - Percutaneous LUNG

ICD-10-CM*	ICD-10-CM Descriptor	ICD-10-PCS	ICD-10-PCS Descriptor
C61	Malignant neoplasm of trachea	0B5_3ZZ	Dest [location] Lung Lobe, Lingula, or Pleura; Percutaneous Approach
C34.--	Malignant neoplasm of [location]; bronchus or lung		
C37	Malignant neoplasm of thymus		
C38.-	Malignant neoplasm [location] mediastinum / pleura		
C45.0	Mesothelioma of pleura		
C76.1	Malignant neoplasm of thorax		
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes		
C78.0-	Secondary malignant neoplasm of 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		
C7A.091	Malignant carcinoid tumor of the thymus		
C96.Z	Other specified malignant neoplasms of lymphoid, hematopoietic and related tissue		
D02.-	Carcinoma in situ of [trachea, bronchus, lung, respiratory system]		
D14.2	Benign neoplasm of trachea		
D14.3-	Benign neoplasm of bronchus and lung		
D15.0	Benign neoplasm of thymus		
D15.2	Benign neoplasm of mediastinum		
D19.0	Benign neoplasm of mesothelial tissue of pleura		
D38.-	Neoplasm of uncertain behavior of [trachea, bronchus, lung, pleura, mediastinum, thymus]		
D3A.090	Benign carcinoid tumor of the bronchus and lung		
D3A.091	Benign carcinoid tumor of the thymus		
E32.8	Other diseases of thymus		
J91.0	Malignant pleural effusion		
J98.51	Mediastinitis		
J98.59	Other diseases mediastinum, NEC		
R22.2	Localized swelling, mass and lump, trunk		
R59.0	Localized enlarged lymph nodes		
R59.1	Generalized enlarged lymph nodes		

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Cryoablation - LIVER

PHYSICIAN SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Physician Fee Schedule		
CPT® Code	CPT® Description	RVUs	Facility	Non Facility
47383	Ablation, 1 or > liver tumors, percutaneous cryoablation	8.88	$436	$5,750
76940	Ultrasound monitoring parenchymal tissue ablation	2.00	$99	$99
77013	CT monitoring parenchymal tissue ablation	3.99	$179	$179
77022	MR monitoring parenchymal tissue ablation	4.24	$195	$195
47000	Biopsy of liver, needle; percutaneous	1.65	$86	$297
76942	Ultrasonic guidance for needle placement, IS&I	0.67	$30	$58
77012	CT guidance for needle placement, IS&I	1.50	$68	$139
77021	MR guidance for needle placement, IS&I	1.50	$70	$425
47371	Laparoscopy, surgical, ablation of 1 or > liver tumors; cryosurgical	20.80	$1,259	NA

OPPS/ASC PROCEDURAL SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Hospital Outpatient	ASC
APC	APC Description	Payment	Payment
5361	Ablation, 1 or > liver tumors, percutaneous cryoablation (CPT 47383)	$5,503	$6,597
5072	Biopsy of liver, needle; percutaneous (CPT 47000)	$1,546	$683
5362	Laparoscopy, surgical, ablation of 1 or > liver tumors; cryosurgical (CPT 47371)	$9,818	$0

HCPCS SUPPLY ITEM REPORTING

Service Provided		Hospital Outpatient	ASC
C-Code	Description	Payment	Payment
C2618*	Probe/needle, cryoablation	Packaged	Packaged

*Must be billed per unit used.

INPATIENT DIAGNOSIS RELATED GROUPS # FY 2024 (10/01/2023-09/30/2024)

Service Provided		Hospital Inpatient
MS-DRG	Description	Payment
405	Pancreas, liver & shunt procedures w/MCC	$38,634
406	Pancreas, liver & shunt procedures w/CC	$19,986
407	Pancreas, liver & shunt procedures w/o CC/MCC	$15,199

See important notes on the uses and limitations of this information on page 4.

ICD-10 Codes

Cryoablation - LIVER

ICD-10-CM*	ICD-10-CM Descriptor	ICD-10-PCS	ICD-10-PCS Descriptor
C22.0	Liver cell carcinoma	OF5-3ZZ	Destruction of "Right, Left or Bilateral" Liver, Open approach
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.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		
D01.5	Carcinoma in situ of liver, gallbladder, and bile ducts		
D13.4	Benign neoplasm of liver		
D37.6	Neoplasm of uncertain behavior of liver, gallbladder, and bile ducts		
D3A.098	Benign carcinoid tumors of other sites		
D3A.8	Other benign neuroendocrine tumors		
D49.0	Neoplasm of unspecified behavior of digestive system		
K76.9	Liver disease, unspecified		

* - indicates more specified coding may be required
_ indicates a value is needed to complete code

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See important notes on the uses and limitations of this information on page 4.

Percutaneous Cryoablation - NERVE

PHYSICIAN SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Physician Fee Schedule		
CPT® Code	CPT® Description	RVUs	Facility	Non Facility
0440T	Ablation, percutaneous, cryoablation, incl imaging guidance; upper ext distal/peripheral nerve	NA	MAC Priced	
0441T	Ablation, percutaneous, cryoablation, incl imaging guidance; lower ext distal/peripheral nerve	NA	MAC Priced	
0442T	Ablation, percutaneous, cryoablation, incl imaging guidance; nerve plexus or other truncal nerve (e.g. brachial plexus, pudendal nerve)	NA	MAC Priced	

OPPS/ASC PROCEDURAL SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Hospital Outpatient	ASC
APC	APC Description	Payment	Payment
5431	Level 1 Nerve Procedures (CPT 0440T, 0441T)	$1,842	$898
5432	Level 2 Nerve Procedures (CPT 0442T)	$6,354	$4,280

HCPCS SUPPLY ITEM REPORTING

Service Provided		Hospital Outpatient	ASC
C-Code	Description	Payment	Payment
C2618*	Probe/needle, cryoablation	Packaged	Packaged

*Must be billed per unit used.

INPATIENT DIAGNOSIS RELATED GROUPS # FY 2024 (10/01/2023-09/30/2024)

Service Provided		Hospital Inpatient
MS-DRG	Description	Payment
073	Cranial & peripheral nerve disorders w/ MCC	$10,999
074	Cranial & peripheral nerve disorders w/o MCC	$7,419

See important notes on the uses and limitations of this information on page 4.

ICD-10 Codes

Percutaneous Cryoablation -NERVE

ICD-10-CM*	ICD-10-CM Descriptor	ICD-10-PCS	ICD-10-PCS Descriptor
C19	Malignant neoplasm of rectosigmoid junction	015_3ZZ	Dest of [location] Nerve; Perc
C20	Malignant neoplasm of rectum		
C21.2	Malignant neoplasm of cloacogenic zone		
C47.1-	Malignant neoplasm of peripheral nerves of upper limb, including shoulder		
C47.2-	Malignant neoplasm of peripheral nerves of lower limb, including hip		
C51.-	Malignant neoplasm of [labium, vulva]		
C52	Malignant neoplasm of vagina		
C53.-	Malignant neoplasm of [location] cervix		
C56.4-	Causalgia of upper limb(s)		
C61	Malignant neoplasm of prostate		
C79.82	Secondary malignant neoplasm of genital organs		
D36.12	Benign neoplasm peripheral nerves and autonomic nervous system, upper limb, including shoulder		
G54.0	Brachial plexus disorders		
G56-G57	Lesion of [location] nerve; upper/lower limb(s)		
G58.-	Mononeuropathy, specified/unspecified		
G90.51-	Complex regional pain syndrome of upper limb(s)		
M12.51-	Traumatic arthropathy, shoulder		
M25.5--	Pain in [shoulder, elbow, joints of hand]		
M50.13	Cervical disc disorder w/ radiculopathy, cervicothoracic		
M54.1-	Radiculopathy, [cervical, cervicothoracic, sacral] reg		
M79.--	Myalgia/Pain in [location]		
N94.81-	Vulvar [vestibulitis, vulvodynia]		
S13.-XXA	Sprain of [joints, ligaments], [location]		
S14.3XXA	Injury of brachial plexus, init		
S16.1XXA	Strain of muscle, fascia, tendon at neck level, init		
S43.42-	Sprain of rotator cuff capsule, init		
S-4.--	Injury of [nerve] at [level or location]; init		
T87.3-	Neuroma of amputation stump; upper extremity		

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Cryoablation - PROSTATE

PHYSICIAN SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Physician Fee Schedule		
CPT® Code	CPT® Description	RVUs	Facility	Non Facility
55873	Cryosurgical ablation of the prostate, incl US monitoring	13.60	$760	$5,665
55700	Biopsy, prostate; needle or punch; 1 or >	2.50	$128	$241
76942	Ultrasonic guidance for needle placement, IS&I	0.67	$30	$58
77012	CT guidance for needle placement, IS&I	1.50	$68	$139
77021	MR guidance for needle placement, IS&I	1.50	$70	$425

OPPS/ASC PROCEDURAL SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Hospital Outpatient	ASC
APC	APC Description	Payment	Payment
5376	Cryosurgical ablation of the prostate, incl US monitoring (CPT 55873)	$8,787	$6,534
5373	Biopsy, prostate; needle or punch; 1 or > (CPT 55700)	$1,943	$930

HCPCS SUPPLY ITEM REPORTING

Service Provided		Hospital Outpatient	ASC
C-Code	Description	Payment	Payment
C2618*	Probe/needle, cryoablation	Packaged	Packaged

*Must be billed per unit used.

INPATIENT DIAGNOSIS RELATED GROUPS # FY 2024 (10/01/2023-09/30/2024)

Service Provided		Hospital Inpatient
MS-DRG	Description	Payment
707	Major male pelvic procedures w/ CC/MCC	$13,811
708	Major male pelvic procedures w/o CC/MCC	$10,550

See important notes on the uses and limitations of this information on page 4.

ICD-10 Codes

Cryoablation - PROSTATE

ICD-10-CM*	ICD-10-CM Descriptor	ICD-10-PCS	ICD-10-PCS Descriptor
C61	Malignant neoplasm of prostate	0V507ZZ	Destruction of Prostate, Via Natural or Artificial Opening
C79.82	Secondary malignant neoplasm of genital organs		
D07.5	Carcinoma in situ of prostate		
D29.1	Benign neoplasm of prostate		
D40.0	Neoplasm of uncertain behavior of prostate		
D49.59	Neoplasm of unspecified behavior of other genitourinary organ		

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Percutaneous Cryoablation - BREAST

PHYSICIAN SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Physician Fee Schedule		
CPT® Code	CPT® Description	RVUs	Facility	Non Facility
19105	Ablation, cryosurgical, breast fibroadenoma, each, incl ultrasound guidance	3.69	$209	$2,264
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral	NA	MAC Priced	

OPPS/ASC PROCEDURAL SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Hospital Outpatient	ASC
APC	APC Description	Payment	Payment
5091	Ablation, cryosurgical, breast fibroadenoma, each, incl ultrasound guidance (CPT 19105)	$3,636	$2,099
NA	Not Covered (CPT 0581T)	Not Covered	

HCPCS SUPPLY ITEM REPORTING

Service Provided		Hospital Outpatient	ASC
C-Code	Description	Payment	Payment
C2618*	Probe/needle, cryoablation	Packaged	Packaged

*Must be billed per unit used.

INPATIENT DIAGNOSIS RELATED GROUPS # FY 2024 (10/01/2023-09/30/2024)

Service Provided		Hospital Inpatient
MS-DRG	Description	Payment
584	Breast biopsy, local excision & other breast procedures w/ CC/MCC	$14,571
585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	$14,127

See important notes on the uses and limitations of this information on page 4.

ICD-10 Codes

Percutaneous Cryoablation - BREAST

ICD-10-CM*	ICD-10-CM Descriptor	ICD-10-PCS	ICD-10-PCS Descriptor
D21.4	Benign neoplasm of right breast	OH5_3ZZ	Destruction of “Right, Left or Bilateral” Breast, Percutaneous approach
D24.2	Benign neoplasm of left breast	OH5_0ZZ	Destruction of “Right, Left or Bilateral” Breast, Open approach
D24.9	Benign neoplasm of unspecified breast		

* - indicates more specified coding may be required
_ indicates a value is needed to complete code

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Percutaneous Cryoablation - BONE

PHYSICIAN SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Physician Fee Schedule		
CPT® Code	CPT® Description	RVUs	Facility	Non Facility
20983	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; cryoablation	6.88	$335	$4,985
20220	Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)	1.65	$86	$231
20225	Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)	2.45	$127	$377
76942	Ultrasonic guidance for needle placement, IS&I	0.67	NA	$58
77012	CT guidance for needle placement, IS&I	1.50	NA	$139
77021	MR guidance for needle placement, IS&I	1.50	NA	$425

OPPS/ASC PROCEDURAL SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Hospital Outpatient	ASC
APC	APC Description	Payment	Payment
5114	Ablate bone tumor(s) perq (CPT 20983)	$6,823	$4,684
5072	Bone biopsy trocar/needle (CPT 20220 & 20225)	$1,546	$683

HCPCS SUPPLY ITEM REPORTING

Service Provided		Hospital Outpatient	ASC
C-Code	Description	Payment	Payment
C2618*	Probe/needle, cryoablation	Packaged	Packaged

*Must be billed per unit used.

See important notes on the uses and limitations of this information on page 4.

INPATIENT DIAGNOSIS RELATED GROUPS # FY 2024 (10/01/2023-09/30/2024)

Service Provided		Hospital Inpatient
MS-DRG	Description	Payment
477	Biopsies of Musculoskeletal System & Connective Tissue w/MCC	$24,474
478	Biopsies of Musculoskeletal System & Connective Tissue w/MCC	$16,642
489	Biopsies of Musculoskeletal System & Connective Tissue w/MCC	$8,815
495	Local Excision & Removal of Internal Fixation Devices Except Hip & Femur w/MCC	$25,054
496	Local Excision & Removal of Internal Fixation Devices Except Hip & Femur w/CC	$14,041
497	Local Excision & Removal of Internal Fixation Devices Except Hip & Femur w/o CC/MCC	$9,558

ICD-10 Codes

Percutaneous Cryoablation - BONE

ICD-10-CM*	ICD-10-CM Descriptor	ICD-10-PCS	ICD-10-PCS Descriptor
		0N5_3ZZ	Destruction of “Right or Left” Head & Facial Bones, Percutaneous Approach
		0P5_3ZZ	Destruction of “Right or Left” Upper Bone, Percutaneous Approach
		0Q5_3ZZ	Destruction of “Right or Left” Lower Bone, Percutaneous Approach

* - indicates more specified coding may be required
_ indicates a value is needed to complete code

Disclaimer

The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

See important notes on the uses and limitations of this information on page 4.

SOURCES

1. FY 2024 IPPS Payment. CMS-1785-F. https://www.cms.gov/medicare/payment/prospective-payment-systems/acuteinpatient-pps/fy-2024-ipps-final-rule-home-page
2. CMS 2024 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-pcs
3. CMS ICD-10-CM/PCS MS-DRG 41.0 Definitions Manual. https://www.cms.gov/files/zip/icd-10-ms-drg-definitions-manual-files-v41.zip
   Not intended as an all-inclusive list of MS-DRGs
4. 2024 Physician Fee Schedule. CMS-1784-F. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1784-f
   2024 *Conversion Factor of $33.2875*
5. 2024 ASC Payment. CMS-1786-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc
6. 2024 OPPS Payment. CMS-1786-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc

See important notes on the uses and limitations of this information on page 4.

The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options. This document is for illustrative purposes only. The descriptions displayed above are not official descriptions. This document should never be used in place of official coding resources and should never have any influence on clinical decisions.

Physician Billing and Payment: Medicare and most other insurers typically reimburse physicians based on fee schedules tied to CPT® codes. CPT codes are published by the AMA and used to report medical services and procedures. Physician payment for procedures performed in a hospital (outpatient or inpatient) or Ambulatory Surgical Center (ASC) setting is described as a Facility fee payment while payment for procedures performed in the physician office is described as a Non-Facility or Global payment. Facility payments use modifier {-26 }, as applicable.

Hospital Outpatient Billing and Payment: Medicare reimburses hospitals for outpatient stays (typically stays that do not span 2 midnights) under Ambulatory Payment Classification (APC) groups. Medicare assigns an APC to a procedure based on the billed CPT/HCPCS (Healthcare Common Procedural Coding System) code. While it is possible that separate APC payments may be deemed appropriate where more than one procedure is done during the same outpatient visit, many APCs are subject to reduced payment when multiple procedures are performed on the same day. Comprehensive APCs (J1 status indicator) can impact total payment received for outpatient services.

Hospitals and Medical Devices: Hospitals must report device category codes (HCPCS C-codes) on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPPS. This reporting provides claims data used annually to update the OPPS payment rates. Although separate payment is not typically available for C-Codes, denials may result if applicable C- Codes are not included with associated procedure codes. CMS has an established cost center for "Implantable Devices Charged to Patients" and uses data from this cost center to establish OPPS payments.

Hospital Inpatient Billing and Payment: Medicare reimburses hospital inpatient procedures based on the Medicare Severity Diagnosis Related Group (MS-DRG). The MS-DRG is a system of classifying patients based on their diagnoses and the procedures performed during their hospital stay. MS-DRGs closely calibrate payment to the severity of a patient's illness. One single MS-DRG payment is intended to cover all hospital costs associated with treating an individual during his or her hospital stay, except for "professional" (e.g., physician) charges associated with performing medical procedures.

ICD-10-PCS: Potential hospital inpatient procedure codes are included within this guide. Due to the number of potential codes within the ICD-10-PCS system, the codes included in this document do not fully account for all procedure code options. Some codes outlined in this guide include an " _" symbol. In these examples, the "_" character could be any possible alphanumeric value depending on the procedure category. The "_" symbol is not a recognized character within the ICD-10-PCS system.

ASC Billing and Payment: Many elective procedures are performed outside of the hospital in Medicare certified facilities also known as ASCs. Not all procedures that Medicare covers in the hospital setting are eligible for payment in an ASC. Medicare has a list of all services (as defined by CPT/HCPCs codes), that it covers when offered in an ASC.

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