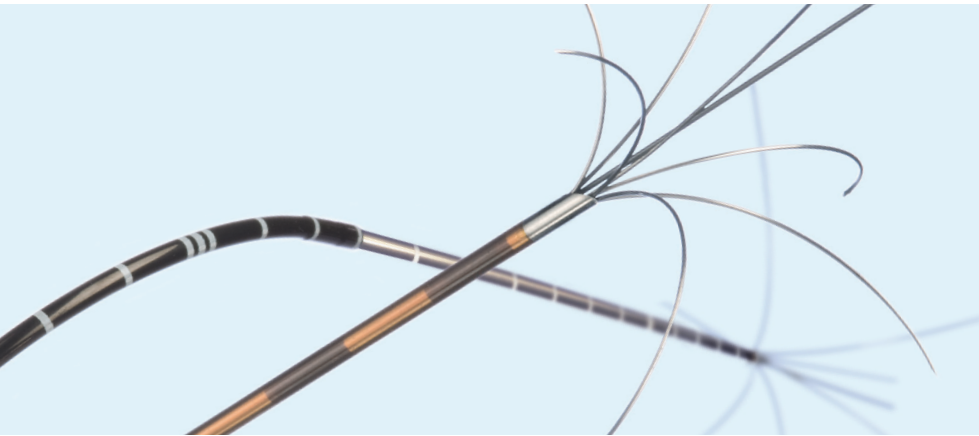


Reimbursement Guidelines

Coding and Reimbursement Guidelines
for Oncology Therapy Products



This is general reimbursement information only; it is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment, nor intended to increase or maximize reimbursement by any third party payer. This information was correct at the time of publication; however, it is always the responsibility of the provider to determine appropriate coding and charges for insurance claims. All coding and reimbursement information is subject to change without notice. Payers or their local branches may have their own coding and reimbursement requirements and policies. Before filing any claims, providers should verify the payer's current requirements and policies.

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There are no C-Codes for AngioDynamics oncology products.

ANGIODYNAMICS®

Liver-Embolization

CPT Code	Medicare Physician Payment	Description	APC Code (Status Indicator)	OPPS Payment
Hepatic Angiogram				
75726	\$240.68 (Global) \$58.46 (Prof) \$182.23 (Tech)	Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation	0279 (Q2)*	\$1,962.36*
75774	\$171.76 (Global) \$18.40 (Prof) \$153.36 (Tech)	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	N	N/A Packaged
Access Celiac Trunk				
36245	\$262.34	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within vascular family	N	N/A Packaged
36246	\$286.51 initial second order abdominal	N	N/A Packaged
36247	\$341.72 initial third order	N	N/A Packaged
36248	\$54.49 additional second order, third order, and beyond (List in addition to code for initial second or third order vessel as appropriate)	N	N/A Packaged
Embolization Procedures				
37204	\$943.97	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	0082 (T)	\$6,290.62*
75894	\$68.56 (Professional)	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	N	N/A Packaged
75898	\$87.32 (Professional)	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	0261 (Q1)*	\$75.23*

*Please note that these services are NOT payable in the ASC setting.

CPT Modifier	Description
-26	Professional Component

MS-DRG	Description	Payment
435	Malignancy of hepatobiliary system or pancreas with MCC	\$9,032
436	Malignancy of hepatobiliary system or pancreas with CC	\$6,179
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	\$4,585
846	Chemotherapy without acute leukemia as secondary diagnosis with MCC	\$11,343
847	Chemotherapy without acute leukemia as secondary diagnosis with CC	\$4,936
848	Chemotherapy without acute leukemia as secondary diagnosis without CC/MCC	\$4,301

ICD-9 Code	Description (Diagnosis Codes)
V58.11	Encounter for antineoplastic chemotherapy
155.0	Malignant neoplasm of liver, primary
155.2	Malignant neoplasm of liver, not specified as primary or secondary
197.7	Secondary malignant neoplasm of liver, specified as secondary

ICD-9 Code	Description (Procedure Codes)
435	Injection or infusion of cancer chemotherapeutic substance
436	Arterial catheterization
437	Arteriography of other intra-abdominal arteries

*Hospital payment for codes with a Q status indicator will be packaged (not separately paid) if the code is reported with any other services that are separately payable under the OPPS on the same date of service (status indicator "S", "T", "V" or "X" if Q1 or status indicator T if Q2).

Liver-RFA

CPT Code	Medicare Physician Payment	Description	APC Code (Status Indicator)	OPPS Payment	ASC Payment
RF Procedures Facility					
47370	\$1,172.39	Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency	0174 (T)	\$7,409.52	Not Covered
47382	\$816.59	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	(N)	\$3,462.09	\$2,057.55
77013	\$206.40 (Professional)	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	(N)	N/A Packaged	N/A Packaged
77022	\$215.79 (Professional)	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	(N)	N/A Packaged	N/A Packaged
76940	\$104.28 (Professional)	Imaging Guidance Ultrasound	(N)	N/A Packaged	N/A Packaged
Open Liver Procedures (Medicare "inpatient only" procedures)					
47380	\$1,370.13	Ablation, open, of one or more liver tumor(s); radiofrequency	(C)	Not Covered	Not Covered

+ = ASC Status Indicator G2

CPT Modifier	Description
-26	Professional Component

MS-DRG	Description	Payment
405	Pancreas, liver and shunt procedures with MCC	\$29,203
406	Pancreas, liver and shunt procedures with CC	\$13,960
407	Pancreas, liver and shunt procedures without CC/MCC	\$9,437

ICD-9 Code	Description (Diagnosis Codes)
155.0	Malignant neoplasm of liver, primary
155.1	Malignant neoplasms intrahepatic bile ducts
155.2	Malignant neoplasm of liver, not specified as primary or secondary
197.7	Secondary malignant neoplasm of liver, specified as secondary
211.5	Benign neoplasm of liver and biliary passages
230.8	Carcinoma in situ of liver and biliary system
235.3	Neoplasm of uncertain behavior of liver and biliary passages
239.0	Neoplasm of unspecified nature of digestive system
570	Acute and subacute necrosis of liver

ICD-9 Code	Description (Procedure Codes)
50.23	Open ablation of liver lesion or tissue
50.24	Percutaneous ablation of liver lesion or tissue
50.25	Laparoscopic ablation of liver lesion or tissue

Reimbursement Terminology

APC:	Ambulatory Payment Classification	ASC (G2):	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
APC (C):	Inpatient Only Procedure; procedure is not covered by Medicare in outpatient settings	CPT	Current Procedural Terminology
APC (N):	Paid under OPPS; payment is packaged into payment for other service	C-Code:	Device category codes reported by hospitals in conjunction with outpatient hospital procedures

Other Soft Tissue-RFA

CPT Code	Medicare Physician Payment	Description	APC Code (Status Indicator)	OPPS Payment	ASC Payment
RF Procedures Facility					
32998	\$301.67	Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral	0423 (T)	\$3,462.09	\$2,057.55 ⁺
77013	\$206.40 (Professional)	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	N	N/A Packaged	N/A Packaged
77022	\$215.79 (Professional)	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	N	N/A Packaged	N/A Packaged
RF Procedures Non-Facility					
32998	\$2,673.15	Ablation therapy for reduction or eradication of one or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral	N/A	N/A	N/A
77013	Carrier Determined	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	N/A	N/A	N/A
77022	Carrier Determined	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	N/A	N/A	N/A

⁺ = ASC Status Indicator G2

CPT Modifier	Description
-26	Professional Component

MS-DRG	Description	Payment
166	Other respiratory O.R. procedures with MCC	\$19,444
167	Other respiratory O.R. procedures with CC	\$10,481
168	Other respiratory O.R. procedures without CC/MCC	\$6,803

ICD-9 Code	Description (Diagnosis Codes)
162.2	Malignant neoplasm of main bronchus
162.3	Malignant neoplasm of upper lobe, bronchus, or lung
162.4	Malignant neoplasm of middle lobe, bronchus, or lung
162.5	Malignant neoplasm of lower lobe, bronchus, or lung
162.8	Malignant neoplasm of other parts of bronchus or lung
162.9	Malignant neoplasm of bronchus and lung, unspecified site
163.0	Malignant neoplasm of parietal pleura
163.1	Malignant neoplasm of visceral pleura
163.8	Malignant neoplasm of other specified sites of pleura
163.9	Malignant neoplasm of pleura, unspecified site

ICD-9 Code	Description (Procedure Codes)
32.24	Percutaneous ablation of lung lesion or tissue

APC (Q1):	Paid under OPPS; packaged APC payment if billed on same date of service as a HCPCS code with status indicator of 'S', 'T', 'V', or 'X';	ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
APC (Q2):	Paid under OPPS; packaged APC payment if billed on same date of service as a HCPCS code with status indicator of 'T'	MS-DRG	Medicare-severity Diagnosis Related Group

Other Soft Tissue-RFA

CPT Code	Medicare Physician Payment	Description	APC Code (Status Indicator)	OPPS Payment	ASC Payment
RF Procedures Facility					
50592	\$374.92	Ablation , one or more renal tumor(s), percutaneous, unilateral, radiofrequency	0423(T)	\$3,462.09	\$2,057.55 ⁺
77013	\$206.40 (Professional)	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	N	N/A Packaged	N/A Packaged
77022	\$215.79 (Professional)	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	N	N/A Packaged	N/A Packaged
76940	\$104.28 (Professional)	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	N	N/A Packaged	N/A Packaged
RF Procedures Non-Facility					
50592	\$3,381.85	Ablation , one or more renal tumor(s), percutaneous, unilateral, radiofrequency	N/A	N/A	\$2,057.55
77013	Carrier Determined	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	N/A	N/A	N/A Packaged
77022	Carrier Determined	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	N/A	N/A	N/A Packaged
76940	Carrier Determined	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	N/A	N/A	N/A Packaged
Laparoscopic Procedures ("Facility" setting only)					
50541	\$954.08	Laparoscopy, surgical, ablation of renal cysts	0130 (T)	\$2,565.07	Not Covered
50542	\$1,210.28	Laparoscopy, surgical, ablation of renal mass lesion(s)	0174 (T)	\$7,409.52c	Not Covered

+ = ASC Status Indicator G2

CPT Modifier	Description
-26	Professional Component

MS-DRG	Description	Payment
656	Kidney and ureter procedures for neoplasms with MCC	\$17,023
657	Kidney and ureter procedures for neoplasms with CC	\$9,674
658	Kidney and ureter procedures for neoplasms without CC/MCC	\$7,138

ICD-9 Code	Description (Diagnosis Codes)
189.0	Malignant neoplasm of kidney, except pelvis
189.1	Malignant neoplasm of renal pelvis
189.8	Malignant neoplasm of other specified sites of urinary organs
189.9	Malignant neoplasm of urinary organ, site unspecified
198.0	Secondary malignant neoplasm of kidney

ICD-9 Code	Description (Procedure Codes)
55.32	Open Ablation for renal lesion or tissue
55.33	Percutaneous ablation of renal lesion or tissue
55.34	Laparoscopic ablation of renal lesion or tissue

APC (S):	Medicare APC payments are reimbursed at 100% for secondary procedures with a status indicator of "S"	Facility	Physician payment level for professional services provided in a facility setting such as a hospital or ambulatory surgery center
APC (T):	Medicare APC payments are reimbursed at 50% for secondary procedures with a status indicator of "T"	Non-Facility	Physician payment level for professional services provided in a non-facility setting such as a physician's office
ASC:	Ambulatory Surgery Center	OPPS:	Outpatient Prospective Payment System

Bone-RFA

CPT Code	Medicare Physician Payment	Description	APC Code (Status Indicator)	OPPS Payment	ASC Payment
RF Procedures Facility					
20982	\$386.11	Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance	0051 (T)	\$3,139.68	\$1,865.93 ⁺
RF Procedures Non-Facility					
20982	\$3,358.39	Ablation, bone tumor(s) (eg, osteoid osteoma, metastasis) radiofrequency, percutaneous, including computed tomographic guidance	N/A	N/A	N/A

+ = ASC Status Indicator G2

MS-DRG	Description	Payment
495	Local excision and removal int fix devices exc hip and femur with MCC	\$15,012
496	Local excision and removal int fix devices exc hip and femur with CC	\$8,489
497	Local excision and removal int fix devices exc hip and femur without CC/MCC	\$5,402

ICD-9 Code	Description (Diagnosis Codes)
170.0	Malignant neoplasm of bones of skull and face, mandible
170.1	Malignant neoplasm of mandible
170.2	Malignant neoplasm of vertebral column, excluding sacrum and coccyx
170.3	Malignant neoplasm of ribs, sternum, and clavicle
170.4	Malignant neoplasm of scapula and long bones of upper limb
170.5	Malignant neoplasm of short bones of upper limb
170.6	Malignant neoplasm of pelvic bones, sacrum and coccyx
170.7	Malignant neoplasm of long bones of lower limb
170.8	Malignant neoplasm of short bones of lower limb
170.9	Malignant neoplasm of bone and articular cartilage, site unspecified

When Bone Cancer is Secondary to Another Malignancy	
198.5	Secondary malignant neoplasm bone and bone marrow

ICD-9 Code	Description (Diagnosis Codes)
01.6	Excision of lesion of skull
76.2	Local excision or destruction of lesion of facial bone
77.60 – 77.69	Local excision of lesion or tissue of bone

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