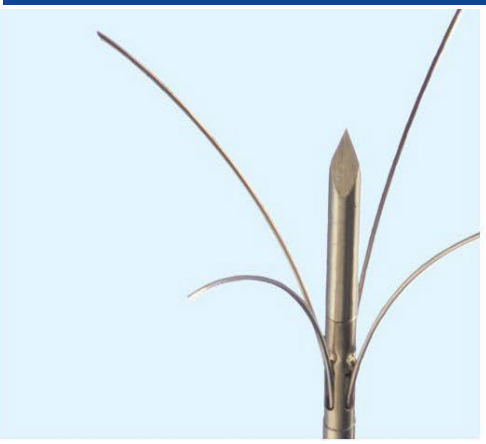
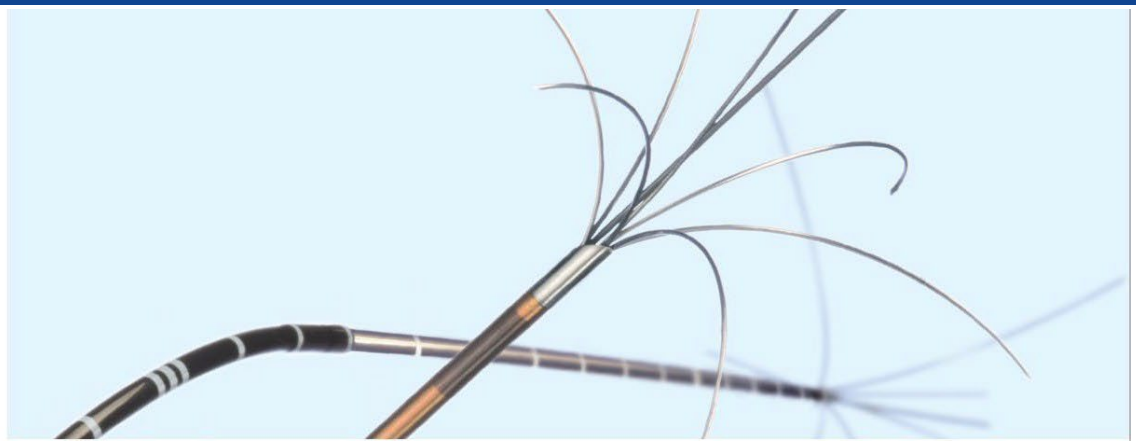
Reimbursement Guidelines

2026 Microwave and Radiofrequency Ablation Reimbursement Coding Guide

EFFECTIVE JANUARY 1, 2026





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Liver Microwave & Radiofrequency Ablation

Physician, Hospital OPPS, ASC Coding & Payment (January 2026 - December 2026)

According to an American Medical Association (AMA) and American College of Radiology (ACR) co-publication[1], "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, the AMA/ACR recommends that microwave ablation be reported using CPT® codes for radiofrequency ablation. Below is a list of commonly reported CPT codes for liver tumor ablations and Medicare national average payment rates.

Medicare 2026 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Reimbursement[3]				Hospital OPPS Payment[4]		ASC Payment[5] (Payment Indicator)
CPT® Code[2]	CPT® Description[2]	Non-Facility		Facility		APC[4] (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
47370	Laparoscopy, surgical, ablation of 1 or more liver tumor(s); radiofrequency	N/A	N/A	35.10	$1,172.37	5362 (J1)	$10,860.07	$5,120.50 (G2)
47382	Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency	102.77	$3,432.61	19.18	$640.63	5361 (J1)	$6,176.47	$3,030.97 (G2)
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	$177.02 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
77022	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	$191.05 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	$102.54 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
Open Liver Procedure (Medicare "Inpatient Only" Procedures)								
47380	Ablation, open, of 1 or more liver tumor(s); radiofrequency	N/A	N/A	40.24	$1,344.05	No APC code (C)	Not Covered	Not Covered
Unlisted Procedures								
47399	Unlisted procedure, liver[6]	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5071 (T)	$723.47	Not Covered

The use of modifier 26 indicates that only the professional component of the procedure was provided.

CPT Modifier	Description
26	Professional Component

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ICD-10-CM Diagnosis Codes (October 2025 - September 2026)

Diagnosis codes are used by physicians and hospitals to document all patient conditions associated with the hospitalization. Secondary diagnosis codes corresponding to additional conditions at the time of admission, or developed subsequently, and which influence the treatment received or the length of stay should be reported. The ICD-10-CM codes below are examples of diagnosis codes that may apply for liver tumor indications[7,8]. The provider should refer to a complete coding authority to check, confirm, and report all codes that accurately describe all the patient's conditions.

ICD-10-CM[7,8]	ICD-10-CM Description (Diagnosis Codes)[7,8]
C22.0	Liver cell carcinoma
C22.1	Intrahepatic bile duct carcinoma
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.098	Malignant carcinoid tumors of other sites
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

The listed ICD-10-PCS procedure codes are examples of codes that may apply for liver tumor ablation procedures.

ICD-10-PCS Code [9]	ICD-10-PCS Description (Procedure Codes)[9]
0F500ZZ	Destruction of Liver, Open Approach
0F503ZZ	Destruction of Liver, Percutaneous Approach
0F504ZZ	Destruction of Liver, Percutaneous Endoscopic Approach
0F510ZZ	Destruction of Right Lobe Liver, Open Approach
0F513ZZ	Destruction of Right Lobe Liver, Percutaneous Approach
0F514ZZ	Destruction of Right Lobe Liver, Percutaneous Endoscopic Approach
0F520ZZ	Destruction of Left Lobe Liver, Open Approach
0F523ZZ	Destruction of Left Lobe Liver, Percutaneous Approach
0F524ZZ	Destruction of Left Lobe Liver, Percutaneous Endoscopic Approach

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Medicare Severity-Diagnosis Related Groups (MS-DRGs) (October 2025 - September 2026)

The following MS-DRGs may apply to liver tumor ablation procedures for Medicare patients. If significant additional procedures are performed during the same inpatient admission, other MS-DRGs may apply.

MS-DRG[10,11]	MS-DRG Description[10,11]	2025 Relative Weight[10]	2025 Medicare Payment[10]
356	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	4.3928	$31,965.35
357	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.3255	$16,922.11
358	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3979	$10,172.18
405	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.4705	$39,807.52
406	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.9002	$21,104.06
407	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	2.2196	$16,151.50

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. The HCPCS codes listed below may be used for endovenous ablation procedures.

HCPCS Code[12]	HCPCS Description[12]	MWA/RF System(s) Product
C1889	Implantable/insertable device, not otherwise classified	MWA/RF Ablation Probes

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Kidney Microwave & Radiofrequency Ablation

Physician, Hospital OPPS, ASC Coding & Payment (January 2026 To December 2026)

According to an American Medical Association (AMA) and American College of Radiology (ACR) co-publication[1], "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, the AMA/ACR recommends that microwave ablation be reported using CPT® codes for radiofrequency ablation. The listed CPT® codes in the table below are examples of codes that may apply to kidney tumor ablation procedures and Medicare national average payment rates.

Medicare 2026 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule[3]				Hospital OPPS Payment[4]		ASC Payment[5] (Payment Indicator)
CPT® Code[2]	CPT® Description[2]	Non-Facility		Facility		APC Code[4] (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
50542	Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	N/A	N/A	31.28	$1,044.78	5362 (J1)	$10,860.07	$5,120.50 (G2)
50592	Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency	78.55	$2,623.64	8.91	$297.60	5361 (J1)	$6,176.47	$3,030.97 (G2)
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	$177.02 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
77022	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	$191.05 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	$102.54 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
Unlisted Procedures								
53899	Unlisted procedure, urinary system[13]	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5371 (T)	$255.26	Not Covered

The use of modifier 26 indicates that only the professional component of the procedure was provided.

CPT Modifier	Description
26	Professional Component

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ICD-10-CM Diagnosis Codes (October 2025 - September 2026)

Diagnosis codes are used by physicians and hospitals to document all patient conditions associated with the hospitalization. Secondary diagnosis codes corresponding to additional conditions at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay should be reported. The codes below are examples of diagnosis codes that may apply for kidney tumor indications[7,8]. The provider should check a complete and authoritative coding source to confirm and report all codes that accurately describe all the patient's conditions.

ICD-10-CM Code[7,8]	ICD-10-CM Description [7,8]
C64.1	Malignant neoplasm of right kidney, except renal pelvis
C64.2	Malignant neoplasm of left kidney, except renal pelvis
C64.9	Malignant neoplasm of unspecified kidney, except renal pelvis
C65.1	Malignant neoplasm of right renal pelvis
C65.2	Malignant neoplasm of left renal pelvis
C65.9	Malignant neoplasm of unspecified renal pelvis
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C7A.093	Malignant carcinoid tumor of the kidney
C80.2	Malignant neoplasm associated with transplanted organ

ICD-10-PCS Procedure Codes (October 2025 - September 2026)

The listed ICD-10-PCS procedure codes are examples of codes that may apply for *kidney tumor ablation* procedures[9].

ICD-10-PCS Code [9]	ICD-10-PCS Description (Procedure Codes)[9]
0T500ZZ	Destruction of Right Kidney, Open Approach
0T503ZZ	Destruction of Right Kidney, Percutaneous Approach
0T510ZZ	Destruction of Left Kidney, Open Approach
0T513ZZ	Destruction of Left Kidney, Percutaneous Approach
0T530ZZ	Destruction of Right Kidney Pelvis, Open Approach
0T533ZZ	Destruction of Right Kidney Pelvis, Percutaneous Approach
0T540ZZ	Destruction of Left Kidney Pelvis, Open Approach
0T543ZZ	Destruction of Left Kidney Pelvis, Percutaneous Approach
BT41ZZZ	Ultrasonography of Right Kidney
BT42ZZZ	Ultrasonography of Left Kidney
BT43ZZZ	Ultrasonography of Bilateral Kidneys

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Medicare Severity-Diagnosis Related Groups (MS-DRGs) (October 2025 - September 2026)

The following MS-DRGs may apply to kidney tumor ablation procedures for Medicare patients[10,11]. If significant additional procedures are performed during the same inpatient admission, other MS-DRGs may apply.

MS-DRG[10,11]	MS-DRG Description[10,11]	2026 Relative Weight[10]	2026 Medicare Payment[10]
656	KIDNEY & URETER PROC FOR NEOPLASM W MCC	3.1838	$23,167.75
657	KIDNEY & URETER PROC FOR NEOPLASM W CC	1.8300	$13,316.47
658	KIDNEY & URETER PROC FOR NEOPLASM W/O CC/MCC	1.5518	$11,292.08
659	KIDNEY & URETER PROC FOR NON-NEOPLASM W MCC	2.5409	$18,489.52
660	KIDNEY & URETER PROC FOR NON-NEOPLASM W CC	1.3217	$9,617.69
661	KIDNEY & URETER PROC FOR NON-NEOPLASM W/O CC/MCC	1.0354	$7,534.36

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. The HCPCS codes listed below may be used for endovenous ablation procedures.

HCPCS Code[12]	HCPCS Description[12]	MWA/RF System(s) Product
C1889	Implantable/insertable device, not otherwise classified	MWA/RF Ablation Probes

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Lung Microwave & Radiofrequency Ablation

Physician, Hospital OPPS, ASC Coding & Payment (January 2026 - December 2026)

According to an American Medical Association (AMA) and American College of Radiology (ACR) co-publication[1], "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, the AMA/ACR recommends that microwave ablation be reported using CPT® codes for radiofrequency ablation. The listed CPT® codes in the table below are examples of codes that may apply to lung tumor ablation procedures and Medicare national average payment rates.

Medicare 2026 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Reimbursement[3]				Hospital OPPS Payment[4]		ASC Payment[5] (Payment Indicator)
CPT® Code[2]	CPT® Description[2]	Non-Facility		Facility		APC Code[4] (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
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, including imaging guidance when performed, unilateral; radiofrequency	87.56	$2,924.58	11.40	$380.77	5361 (J1)	$6,176.47	$3,030.97 (G2)
77013	Computed tomography guidance for, and monitoring of, parenchymal tissue ablation	$177.02 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
77022	Magnetic resonance imaging guidance for, and monitoring of, parenchymal tissue ablation	$191.05 (Professional Fee Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	$102.54 (Professional Component)				No APC code (N)	N/A Packaged	N/A Packaged (N1)
Unlisted Procedures								
32999	Unlisted procedure, lungs and pleura[14]	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5181 (T)	$640.89	Not Covered

The use of modifier 26 indicates that only the professional component of the procedure was provided.

CPT Modifier	Description
26	Professional Component

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ICD-10-CM Diagnosis Codes (October 2025- September 2026)

Diagnosis codes are used by physicians and hospitals to document all patient conditions associated with the hospitalization. Secondary diagnosis codes corresponding to additional conditions at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay should be reported. The codes below are examples of diagnosis codes that may apply for lung tumor indications.[7,8] The provider should check a complete and authoritative coding source to confirm and report all codes that accurately describe all the patient's conditions.

ICD-10-CM Code[7,8]	ICD-10-CM Description [7,8]
C34.00	Malignant neoplasm of unspecified main bronchus
C34.01	Malignant neoplasm of right main bronchus
C34.02	Malignant neoplasm of left main bronchus
C34.10	Malignant neoplasm of upper lobe, unspecified bronchus or lung
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.30	Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.80	Malignant neoplasm of overlapping sites of unspecified bronchus and lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part of right bronchus or lung
C34.92	Malignant neoplasm of unspecified part of left bronchus or lung
C38.4	Malignant neoplasm of pleura
C45.0	Mesothelioma of pleura
C76.1	Malignant neoplasm of thorax
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left 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

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ICD-10-PCS Procedure Codes (October 2025 - September 2026)

The listed ICD-10-PCS procedure codes are examples that may apply for lung tumor ablation procedures[9].

ICD-10-PCS Code[9]	ICD-10-PCS Description [9]
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
0B5N3ZZ	Destruction of Right Pleura, Percutaneous Approach
0B5P3ZZ	Destruction of Left Pleura, Percutaneous Approach
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
0B5N0ZZ	Destruction of Right Pleura, Open Approach
0B5P0ZZ	Destruction of Left Pleura, Open Approach

Medicare Severity-Diagnosis Related Groups (MS-DRGs) (October 2025 - September 2026)

The following MS-DRGs may apply to lung tumor ablation procedures for Medicare patients[14,15]. If significant additional procedures are performed during the same inpatient admission, other MS-DRGs may apply.

MS-DRG[10,11]	MS-DRG Description[10,11]	2026 Relative Weight[10]	2026 Medicare Payment[10]
163	MAJOR CHEST PROCEDURES W MCC	4.4818	$32,612.98
164	MAJOR CHEST PROCEDURES W CC	2.5240	$18,366.54
165	MAJOR CHEST PROCEDURES W/O CC/MCC	1.9142	$13,929.17
166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.7377	$27,198.35
167	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.8034	$13,122.91
168	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3664	$9,942.96

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Other Soft Tissue Microwave & Radiofrequency Ablation

Physician, Hospital OPPS, ASC Coding & Payment (January 2026 - December 2026)

The table of CPT® codes noted below are unlisted CPT® codes that may apply to microwave & radiofrequency ablation of other soft tissue tumors. For other types of tumors where no such microwave or radiofrequency CPT® codes exist, an unlisted code for the anatomic area on which the procedure is performed should be reported[14].

Medicare 2026 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule[3]				Hospital OPPS Payment[4]		ASC Payment[5] (Payment Indicator)
CPT® Code[2]	CPT® Description[2]	Non-Facility		Facility		APC Code[4] (Status Indicator)	Payment	
		RVUs	Payment	RVUs	Payment			
19499	Unlisted procedure, breast	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5091 (J1)	$4,000.24	Not Covered
49999	Unlisted procedure, abdomen, peritoneum and omentum	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5301 (T)	$926.63	Not Covered
60699	Unlisted procedure, endocrine system (for adrenal or thyroid tumors)	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5361 (J1)	$6,176.47	Not Covered
38589	Unlisted laparoscopy procedure, lymphatic system	Medicare does not set a national payment for unlisted CPT codes. Check with local Medicare contractor				5361 (J1)	$6,176.47	Not Covered

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. The HCPCS codes listed below may be used for endovenous ablation procedures.

HCPCS Code[12]	HCPCS Description[12]	MWA/RF System(s) Product
C1889	Implantable/insertable device, not otherwise classified	MWA/RF Ablation Probes

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Reimbursement Terminology

Term	Description
APC	Ambulatory Payment Classification
APC (C)	Not paid under OPPS. Admit patient. Bill as inpatient.
APC (N)	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
APC (Q1)	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “S”, “T”, or “V". (2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria.Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made through a separate APC payment.
APC (Q2)	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “T”. (2) In other circumstances, payment is made through a separate APC payment.
APC (J1)	Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
APC (T)	Procedure or Service; Multiple Procedure Reduction Applies. Paid under OPPS; separate APC payment.
ASC	Ambulatory Surgery Center
APC (S)	Procedure or Service, Not Discounted When Multiple. Paid under OPPS; separate APC payment.
ASC (G2)	Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
ASC (N1)	Packaged service/item; no separate payment made.
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
C-Code	Device category codes reported by hospitals in conjunction with outpatient hospital procedures
Facility	Physician payment level for professional services provided in a facility setting such as a hospital or ambulatory surgery center
Non- Facility	Physician payment level for professional services provided in a non-facility setting such as a physician’s office
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
IPPS	Inpatient Prospective Payment System
MS-DRG	Medicare Severity-Diagnosis Related Group
OPPS	Outpatient Prospective Payment System
W MCC	With Major Complications and Comorbidities
W CC	With Complications and Comorbidities
W/O CC/MCC	Without complications or comorbidities, and without major complications and comorbidities.

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References

1. "As currently practiced, CPT codes 32998, 47382, and 50592 should be used for both microwave and radiofrequency ablation in their respective anatomic locations in conjunction with the associated imaging guidance code (e.g., 76940, 77013, or 77022). 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. Microwave ablation equipment is substantially comparable to operate in practice, which is also reflected in the US Food and Drug Administration (FDA) approval of microwave devices under the 510(k)-clearance process as equivalent to radiofrequency." American Medical Association (AMA) and American College of Radiology (ACR), "Clinical Examples in Radiology: A Practical Guide to Correct Coding". Volume 8, Issue 3. Summer 2012.
2. CPT © 2026 Professional. American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the AMA. No fee schedules, basic units, relative values, or related listings are included in CPT® including for Category 3 codes. Inclusion of a CPT® code does not represent AMA endorsement or imply any coverage or reimbursement policy. Reimbursement information here is from the Centers for Medicare and Medicaid Services (CMS), see sources below. Applicable FARS/DFARS restrictions apply to Government Use.
3. Physician fee schedule rates were calculated using Conversion Factor (33.4009) multiplied by Total Facility & Non-Facility RVUs. CMS, CMS 1832-F: Revisions to Payment Policies under the Medicare Physician Fee Schedule Quality Payment Program and Other Revisions to Part B for CY 2026 https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f. Published November 5, 2025. Effective January 1, 2026. Accessed December 5, 2025.
4. CMS, CMS-1834-FC https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc Hospital Outpatient Prospective Payment- Notice of Final Rulemaking with Comment Period (NFRM). Published November 25, 2025. Effective January 1, 2026. Accessed December 5, 2025.
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6. Use 47399 to report procedures in the liver that do not have a specific code.
7. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). 2026 release of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) . Updated September 2025. Accessed December 5, 2025. https://www.cdc.gov/nchs/icd/icd-10-cm/index.html.
8. AAPC Complete Coder, Cross-Reference "CPT® code - ICD-10-CM Crosswalk" Accessed December 5, 2025.
9. CMS, 2026 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf. Accessed December 5, 2025.
10. CMS, [CMS-1833-F] 2026 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule; Federal Register. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page. Payment is calculated based on the national adjusted standardized amount $7,276.76. Actual Medicare payment rates will vary from adjustments by Wage Index and Geographic Adjustment Factor depending on geographic locality. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown. Accessed September 10, 2025.
11. AAPC. 2026 HCPCS Level II Expert: Service Supply Codes for Caregivers and Suppliers. American Academy of Professional Coders; 2026.
12. Use 53899 to report procedures in the kidney that do not have a specific code.
13. Use 32999 to report procedures in the lung that do not have a specific code.

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14. CPT® guidelines instruct that you should not choose a code that merely approximates the service provided. You should report the service using only the appropriate unlisted procedure code if no such specific procedure or service code exists. You must report a Category III code when available in place of an unlisted procedure code. When reporting a procedure with an unlisted code, submit a cover letter explaining the reason for choosing the unlisted code instead of a defined, active code. Include one or more similar codes and compare your service to those codes to justify the claim amount you are billing. Also include the operative notes or other relevant documentation to strengthen the claim and to avoid a possible denial. Your payors will consider claims with unlisted procedure codes on a case-by-case basis, and they will determine payment based on the documentation you provide.

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Solero
Microwave Tissue Ablation System

Habib

RISK INFORMATION

Habib 2X Laparoscopic or Habib 4X Laparoscopic Devices:

Indications for Use: The Habib 4X or 2X Laparoscopic device is intended to be used to assist in coagulation of tissue during intraoperative and laparoscopic surgical procedures.
Contraindications: Do not use on patients with cardiac pacemakers or other active implants.
Warnings:

- Do not attach anything (i.e., clamps, etc.) to the device. This may damage the insulation, which could contribute to patient injury.
- Take care when handling as needles can cause injury.
- Do not use if needles are bent or damaged, as it could lead to patient injury.
- Please refer to the generator's user manual for warnings and precautions associated with the use of the generator.

Side Effects: The potential side effects associated with liver surgery are: general problems related to general anesthetics, bleeding, liver abscess, bile leak, liver failure, subphrenic abscess, postoperative heart failure, chest infection, wound dehiscence, wound infection or incisional hernia.
Refer to Directions for Use and/or User Manual provided with the product for complete Instructions, Warnings, Precautions, Possible Adverse Effects and Contraindications prior to use of the product.
RX ONLY or CAUTION: Federal law (USA) restricts this device to sale by or on the order of a physician.

Habib 4X

Indications for Use: The Habib 4X device is intended to be used to assist in intraoperative coagulation of tissue during surgical procedures.
Contraindications: Do not use on patients with cardiac pacemakers or other active implants.
Warnings:

- Do not attach anything (i.e., clamps, etc.) to the device. This may damage the insulation, which could contribute to patient injury.
- Take care when handling as needles can cause injury.
- Do not use if needles are bent or damaged, as it could lead to patient injury.
- Please refer to the generator's user manual for warnings and precautions associated with the use of the generator. Do not use Dispersive Pad(s) with the Habib 4X device. Using dispersive pad(s) will reduce the effectiveness of the Habib 4X device and will create an unintended current path from the Habib 4X electrode to the dispersive pad(s).

Side Effects: The potential side effects associated with liver surgery are: general problems related to general anesthetics, bleeding, liver abscess, bile leak, liver failure, subphrenic abscess, postoperative heart failure, chest infection, wound dehiscence, wound infection or incisional hernia.
Refer to Directions for Use and/or User Manual provided with the product for complete Instructions, Warnings, Precautions, Possible Adverse Effects and Contraindications prior to use of the product. CAUTION: Federal law (USA) restricts this device to sale by or on the order of a physician.
RX ONLY or CAUTION; Federal law (USA) restricts this device to sale by or on the order of a physician.

Solero Microwave Tissue Ablation System

Indication for Use: US: The Solero Microwave Tissue Ablation (MTA) System and accessories are indicated for the ablation of soft tissue during open procedures. The Solero MTA System is not intended for cardiac use. CE: The Solero Microwave Tissue Ablation (MTA) System and Accessories are indicated for the ablation of soft tissue* during open, laparoscopic, or percutaneous procedures. The Solero MTA System is not intended for cardiac use.
*Note Canada Only: Throughout this document any reference to "soft tissue" means the following tissue types: Liver, Kidney, and Lung (early-stage non-small cell lung cancer (NSCLC) and inoperable pulmonary malignancies).
RX ONLY or CAUTION: Federal law (USA) restricts this device to sale by or on the order of a physician.
Contraindications: The applicators are contraindicated in patients with heart pacemakers and other electronic device implants.
Refer to Directions for Use and/or User Manual provided with the product for complete Instructions, Warnings, Precautions, Possible Adverse Effects and Contraindications prior to use of the product. CAUTION: Federal law (USA) restricts this device to sale by or on the order of a physician.

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