2026 Nova Fiducial Markers Cancer Hospital Coding and Reimbursement Guide

INTRODUCTION

The information contained in this document is provided to assist health care providers understand reimbursement guidelines and procedures. It is intended to help obtain accurate coding, coverage and payment for medically necessary health care services provided to patients under physician orders. It is not intended to increase or maximize reimbursement.

The information referenced is based upon coding experience and research of current coding practices and published payer policies. They are based upon commonly used codes and procedures. The final decision for coding of any procedure must be made by the provider of care considering the medical necessity of the services, supplies provided and the regulations of insurance carriers including local, state or federal laws that apply.

Although a particular service or supply may be considered medically necessary by the provider, the final coverage decision is based upon a review of the available clinical information and does not mean the service or supply will be covered by any payer. Each payer and benefit plan contains its own specific provisions for coverage and detailed exclusions. Please consult individual payers to determine policy specific guidelines and whether there are any exclusions or other benefit limitations applicable to a particular service or supply.

CODING METHODOLOGY

The Physicians' Current Procedural Terminology® (CPT) developed by the American Medical Association (AMA) and HCPCS Level II codes developed by the Centers for Medicare and Medicaid Services (CMS) are listings of descriptive and identifying codes for medical services and procedures performed by health care providers and reported to third party carriers. The codes in the CPT Manual are copyrighted by the AMA and updated annually by the CPT Editorial Panel.

Third party payers have adopted the CPT and HCPCS coding systems for providers to communicate services provided to patients. Therefore, it is important to identify the services and supplies to accurately adjudicate claims. For this system to be effective, it is essential that the coding description accurately describes what transpired at the patient encounter.

CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to ensure that payment policies and procedures were standardized for all Medicare Administrative Contractors (MACs) to promote correct coding methodologies. The coding edits developed are based on coding conventions defined in the AMA's CPT manual, national and local policies, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and reviews of current coding practice.

Procedures should be reported with the CPT/HCPCS codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code or when a single payment episode is split into two or more episodes so multiple payments can be collected.

The NCCI edits have been developed for application to services billed by a single provider for a single patient on the same date of service. The NCCI represents a more comprehensive approach to unifying coding practices. Quarterly updates are available for hospitals and physicians at Medicare National Correct Coding Initiative (NCCI) Edits.

The Nova Fiducial Marker is intended to identify the location of normal or diseased tissue for future evaluation or treatments. The device is placed at or near the treatment or evaluation site through commercially available compatible needles chosen by the user and can be visualized in subsequent magnetic resonance imaging (MRI), computed tomography (CT), or x-ray studies. The procedure codes provided in the guide reflect the potential codes available for the placement of the Nova Fiducial Marker. Providers should report the appropriate treatment planning, management, and delivery codes separately.

Always code appropriately based upon medical necessity of procedures performed and supporting documentation

Information current as of January 16, 2026

CANCER HOSPITAL PAYMENT ADJUSTMENT

Since the inception of the Outpatient Prospective System (OPPS), Medicare has paid the 11 cancer designated hospitals the meet the criteria for covered outpatient department services under a different payment system. In order to limit the decline in reimbursement for these hospitals, Medicare pays the full amount of the difference between the payments for covered outpatient departments under the OPPS and a pre-BBA amount.

These cancer hospitals are held harmless to their pre-BBA and receive transitional payment or hold harmless payments to ensure they are not paid a lower rate under the OPPS than they would have been paid previous to the implementation of the OPPS. According to Medicare the pre-BBA amount is the product of the hospital's reasonable costs for covered outpatient department services occurring in the current year and the base payment-to-cost (PCR) for the hospital defined in section 1833(t)(7)(F)(ii) of the Act.

Eash year at the time of the Medicare OPPS final rule, a payment adjustment is estimated for each hospital. The adjustment is meant to equal each hospital's final PCR to the weighted average of target PCR for other hospitals paid under the OPPS. The PCR is caclalted annually and in advance of the corresponding calendar year based on the most recent submitted or settled cost report available for the calendar year. The actual payment adjustment is not made at an individual code level, instead, Medicare will make the payment adjustment on an aggregate basis at cost report settlement.

Due to the different payment policy for cancer hospitals, these hospitals are also exempt from many of the standard payment policies or midels. Each year Medicare calculated the target PCR to use in determining the estimated percentage increase in OPPS payments. For CY 2026, Medicare finalized a target PCR of 0.87. Based on this, the estimated payment adjustment percentages are as follows for the 11 cancer designated hospitals.

Estimated Cy 2026 Hospital-Specific Payment Adjustment for Cancer Hospitals to Be Provided at Cost Report Settlement		
Provider Number	Hospital Name	Estimated % Increase in OPPS Payment for CY 2026 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	36.9%
050660	USC Norris Cancer Hospital	36.3%
100079	Sylvester Comprehensive Cancer Center	30.9%
100271	H Lee Moffitt Cancer Center & Research Institute	16.6%
220162	Dana Farber Cancer Institute	46.4%
330154	Memorial Sloan-Kettering Cancer Center	40.9%
330354	Roswell Park Cancer Institute	11.9%
360242	James Cancer Hospital & Solove Research Institute	20.9%
390196	Fox Chase Cancer Center	18.2%
450076	MD Anderson Cancer Center	48.5%
500138	Seattle Cancer Care Alliance	49.4%

PLACEMENT OF NOVA FIDUCIAL MARKER

In the hospital outpatient prospective payment system (OPPS) CMS assigns all CPT and HCPCS codes a status indicator (SI) to indicate if and how a service is reimbursed. In the Ambulatory Surgical Center (ASC), CMS assigns CPT and HCPCS codes a Payment Indicator (PI) to indicate how payment is determined.

*Status Indicators (SI) and Payment Indicators (PI)

- **G2** Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
- **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 SI=F, G, H, L and U. ASC Note: Comprehensive APCs do not apply; procedures are paid separately
- **N/N1** Payment packaged with the primary procedure
- **Q1** Packaged APC payment if billed on same date of service as a HCPCS assigned status indicator "S", "T", "V". In all other circumstances, payment is made through a separate APC payment.
- **P3** Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs
- **S** Separate payment under OPPS; not subject to multiple procedure discount
- **T** Separate payment under OPPS; subject to multiple procedure discount

CPT/HCPCS	Descriptor	OPPS	
		SI*	Payment
A4648∞	Tissue marker, implantable, any type, each	N	Packaged
	Soft Tissue Placement		
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	T	$723
+10036	; each additional lesion	N	Packaged
	Breast Placement		
19281◊	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance	Q1	$1,687
+19282	; each additional lesion	N	Packaged
19283◊	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	Q1	$723
+19284	; each additional lesion	N	Packaged
19285◊	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance	Q1	$723
+19286	; each additional lesion	N	Packaged
19287◊	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance	Q1	$723
+19288	; each additional lesion	N	Packaged
	Thoracic Placement		
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	J1	$7,210
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	S	$1,414
	Abdomen/Pelvis (Non-Prostate) Placement		
+49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple	N	Packaged

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CPT/HCPCS	Descriptor	OPPS	
		SI*	Payment
49411µ	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	S	$1,414
+49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	N	Packaged
	Prostate Placement		
55876 µ	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple	S	$1,414
	Image Guidance for Fiducial Marker Placement		
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	N	Packaged
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	N	Packaged
77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	N	Packaged
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	N	Packaged

+ Denotes add-on code; report in addition to primary procedure
∞ A4648 must be submitted on the same claim form as the procedure with which it is provided.
◊ CPT codes 19281, 19283, 19285, 19287 and 10035 are device intensive procedures in the OPPS and 55876 is a device intensive procedure in both the OPPS and ASC. Failure to report A4648 with these codes will result in claim denial.
µ Per CMS Transmittal 745, A4648 is separately paid in the office-setting when reported with CPT 49411 and 55876

REFERENCES

- CY 2026 Medicare OPPS & ASC Payment System Final Rule (CMS-1834-FC); Addendum B and ASC Addenda.
- CY 2026 Physician Fee Schedule Final Rule (CMS-1832-F); Addendum B. All MPFS Fee Schedules calculated using the Non-Qualifying QP CF of $33.4009.
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