2026 Nova Fiducial Markers 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

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Information current as of January 16, 2026

C4 | IMAGING NOVA Z FIDUCIAL MARKER

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C4 | IMAGING NOVA MR FIDUCIAL MARKER

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		ASC		Physician (MPFS)	
		SI*	Payment	PI*	Payment	Non-Facility	Facility
Nova Fiducial Marker							
A4648ϒμ	Tissue marker, implantable, any type, each	N	Packaged	N1	Packaged	Invoice†	N/A
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	N1	Packaged	$346	$71
+10036	; each additional lesion	N	Packaged	N1	Packaged	$294	$37
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	N1	Packaged	$235	$84
+19282	; each additional lesion	N	Packaged	N1	Packaged	$165	$41
19283◊	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	Q1	$723	N1	Packaged	$250	$84
+19284	; each additional lesion	N	Packaged	N1	Packaged	$181	$42
19285◊	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance	Q1	$723	N1	Packaged	$351	$72
+19286	; each additional lesion	N	Packaged	N1	Packaged	$287	$36
19287◊	Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance	Q1	$723	N1	Packaged	$600	$106
+19288	; each additional lesion	N	Packaged	N1	Packaged	$458	$53
Thoracic Placement							
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	J1	$7,210	G2	$2,451	$870	$179
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	S	$1,414	G2	$759	$494	$153

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CPT/HCPCS	Descriptor	OPPS		ASC		Physician (MPFS)	
		SI*	Payment	PI*	Payment	Non-Facility	Facility
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	N1	Packaged	N/A	$117
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	P3	$346	$475	$159
+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	N1	Packaged	N/A	$74
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	J8	$981	$153	$92
Image Guidance for Fiducial Marker Placement							
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	N	Packaged	N1	Packaged	$65	$32
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	N	Packaged	N1	Packaged	$122	$27
77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation	N	Packaged	N1	Packaged	$123	$67
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	N1	Packaged	$431	$70

+ 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.
- 2026 CPT Professional, ©2025 American Medical Association

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