ACES™ System

(Automatic Continuous Effusion Shunt)

Medicare 2026
Coding and Reimbursement Guide

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Introduction

Pleural Dynamics is pleased to provide this Reimbursement Guide for the FDA-cleared ACES™ System. ACES is a one-piece, fully implanted system, placed during an inpatient or outpatient stay. The System is designed to use normal breathing motion to automatically and continuously pump pleural effusion fluid out of the chest to the abdomen for reabsorption by the body.

This guide is intended to provide our customers with reimbursement information designed to minimize reimbursement problems and questions and to help facilitate appropriate claims submission. Medicare policies play an influential role with respect to the policies established by other third-party payors. Therefore, throughout this guide, Medicare coding, coverage and payment guidelines are referenced unless otherwise indicated.

CONTACT US

For questions regarding coding, coverage or payment of the ACES System, contact our Reimbursement Hotline at:
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DISCLAIMER

This information is provided by Pleural Dynamics as a guide for coding consideration of services involving the ACES™ System. It is not intended to increase or maximize reimbursement by any payor nor is it intended to drive coding or reimbursement decisions. Consult your payor organizations with regard to local coverage, coding and reimbursement policies. Providers assume responsibility for all reimbursement decisions or actions. The codes listed in this guide are options only and not recommendations for payment or coverage.

Hospital Inpatient

ICD-10 Diagnosis codes

For a complete list of ICD-10 diagnosis codes, refer to the *ICD-10-CM 2026 Codebook*. Coding should be based on documentation in the patient's medical record. The following is an example diagnosis code:

Code	Description
J90	Pleural effusion, not elsewhere classified

Inpatient Procedure Codes ICD-10 PCS Codes (examples only)

Coding should be based on documentation in the patient's medical record. Depending on procedure(s) performed, multiple codes may be reported. For a list of all possible ICD-10 procedure codes, refer to *the ICD-10-PCS 2026 Codebook.*

ICD-10 PCS	Description
0W190JG	Bypass Right Pleural Cavity to Peritoneal Cavity with Synthetic Substitute, Open Approach
0W1B0JG	Bypass Left Pleural Cavity to Peritoneal Cavity with Synthetic Substitute, Open Approach
0W193JG	Bypass Right Pleural Cavity to Peritoneal Cavity with Synthetic Substitute, Perc Approach
0W1B3JG	Bypass Left Pleural Cavity to Peritoneal Cavity with Synthetic Substitute, Perc Approach

Medicare 2026 Hospital Inpatient Payment

Hospitals are reimbursed by Medicare for inpatient procedures and services under the FY2026 Inpatient Prospective Payment System (IPPS), which utilizes the Medicare Severity Diagnosis Related Group (MS-DRG) system. Each MS-DRG payment amount includes the cost of all devices. The following are typical MS-DRGs assigned based on procedure and diagnoses. Assignment will vary based on diagnosis(es) and procedure(s) performed.

MS-DRG	Description	FY2026 MS-DRG Base Rate[1]
ACES System when the Primary Diagnosis is Malignant Pleural Effusion		
180	Respiratory Neoplasms with MCC*	$12,851
181	Respiratory Neoplasms with CC*	$7,793
182	Respiratory Neoplasms without CC/MCC	$5,414
ACES System		
186	Pleural Effusion with MCC	$11,341
187	Pleural Effusion with CC	$7,197
188	Pleural Effusion without CC/MCC	$5,219
ACES System + Thorascopy and/or Biopsy		
166	Other Respiratory System OR Procedures with MCC	$27,198
167	Other Respiratory System OR Procedures with CC	$13,123
168	Other Respiratory System OR Procedures without CC/MCC	$9,943

**MCC: Major complication or comorbidity; CC: Complication or comorbidity*

2026 Hospital Outpatient

Medicare Hospital Outpatient - Coding and Payment[2]

Hospitals are reimbursed by Medicare for outpatient procedures and services performed under the Outpatient Prospective Payment System (OPPS), which utilizes the CY2026 Ambulatory Payment Classification (APC) system.

Medicare Coding and Payment - Medicare Traditional (Fee for Service)

(New Technology APC, eff 10-1-2025)

Effective October 1, 2025, CMS established HCPCS code C8006, insertion of a pleural-peritoneal shunt with an intercostal pump chamber, to describe the ACES procedure.[3]

HCPCS Code	Description	2026 APC/Status Indicator	Medicare 2026 Hospital Outpatient Natl Payment
ACES System Implant – Code separately for thoracoscopy, if performed			
C8006	Insertion of pleural-peritoneal shunt with intercostal pump chamber, including imaging, injection(s) of contrast with radiological supervision and interpretation, when performed	**5342/J1** Level 2 Abd/ Peritoneal/Biliary and Related Procedures	**$6,614**

^ All procedures performed same day in hospital outpatient setting are packaged into highest paying J1 status code.

Facility – Medicare Traditional Frequently Asked Questions

Q: Is the new C-code (C8006) payable by Medicare Advantage and commercial payors?

A: New Technology APCs are part of the payment system for original Medicare (Fee for Service) outpatient services, but Medicare Advantage plans nor commercial payors are required to use them. Providers should check with non-Medicare payors to determine if they will accept the C-code or prefer existing or unlisted CPT codes.

Q. Is there anything the facility needs to do to use this new code?

A. To avoid compliance risks and claim denials, consider these best practices:

- **Update Your Chargmaster!** Ensure the new ACES HCPCS code (C8006) and revenue code is integrated into your system.
- **Ensure correct pricing**: Price the new technology appropriately to ensure that when the hospital's CCR is applied, it accurately reflects the cost of providing the service.
- **Educate Your Billing Team:** Conduct training sessions for coders and billers on the new code.
- **Monitor Compliance Metrics:** Track denial rates closely in Q4 to catch coding-related errors early.

Commercial Payors (including Medicare Advantage)

New Technology APCs are part of the payment system for Traditional Medicare (Fee for Service) outpatient services, not necessarily Medicare Advantage. Medicare uses New Technology APCs to pay for new outpatient services until enough claims data is collected to assign them to a standard clinical APC. This is a separate process from how Medicare Advantage plans are paid, and their use of new technology is subject to the plan's own benefits and medical review.

Commercial Payor/Medicare Advantgage Coding Considerations

While many commercial payors follow Traditional Medicare when it comes to coding options, it is not a requirement. **Providers should check with payors to determine if they will accept the C-code or prefer existing or unlisted CPT codes.**

In the event the payor does not accept the new C-code (C8006), the following 2 options may be considered for hospital outpatient coding. These codes should only be used if the payor indicates that will not accept C8006.

Combination of Existing Codes

CPT Code	Description
ACES System Implant – Code all procedures performed, including thoracoscopy, when applicable	
49418 **AND**	Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous
32556	Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance

Unlisted Code

Coding is at the discretion of the provider based on medical necessity and documentation; the unlisted code may be considered at payer direction or if no specific code or combinations of codes exists.

CPT Code	Description
32999	Unlisted procedure, lungs and pleura

Physician

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Physician – Coding and Payment[4]

Physicians are reimbursed for services under the Medicare Physician Fee Schedule (MPFS) using CPT codes. Coding is at the discretion of the provider based on medical necessity and documentation.

Coding Option 1

No single CPT code describes the implant procedure of the ACES System. Until new codes are effective, the combination of CPT codes 49418 and 32556 are likely most appropriate to report the implant procedure.

- Generally, diagnostic procedures performed on the same date of service are billed separately (e.g., ultrasound evaluation, thoracoscopy).
- Use of visualization (e.g., laparoscopy, fluoroscopic guidance and contrast injection) is considered included in the surgical procedure and not separately reported.

CPT Code	Description	2026 Physician Work RVUs	Medicare 2026 Physician Payment (Facility)*	Medicare 2026 Physician Payment (Non-Facility)*
ACES System Implant - Code all procedures performed				
49418	Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous	3.86	$175	$940
32556	Pleural drainage, percutaneous, with insertion of indwelling catheter**; without** imaging guidance	2.44	$112	$842

* Facility payment is made when physician performs the procedure in a facility setting such as hospital; Non-facility payment is made when physician performs procedure or service in office or freestanding facility; payment in this site of service is higher to account for overhead costs, personnel, supplies, etc.
Multiple procedure reduction applies; highest paying procedure 100%, secondary procedures 50%, add-on codes 100%.

Physician (continued)

Coding Option 2

If the provider feels there are no codes that accurately describe the implant procedure, unlisted code 32999 ("Unlisted procedure, lungs and pleura") may be an appropriate option.

CPT Code	Description	Medicare 2026 Physician Payment
32999	Unlisted procedure, lungs and pleura	No RVUs or payment assigned

General Documentation requirements for unlisted CPT code

Most payors will require the following information:

- A clear description of the nature, extent, and need for the procedure or service;
- Whether the procedure was performed independently from other services provided or if it was performed at the same surgical site or through the same surgical opening;
- Operative or procedure report;
- Comparable CPT/HCPCS procedure code, when possible;
- The time, effort, and equipment necessary to provide the service; and
- Any extenuating circumstances that may have complicated the service or procedure;

Other items to consider submitting include:

- The history and physical (H&P) or other note showing the decision to do the surgery was made with the patient, and the medical necessity of such;
- A cover letter with a brief summary of why an unlisted code was used;
- A discharge summary; and
- Any diagnostic reports.

Pricing an unlisted code

Unlisted codes do not have payment rates or relative value units (RVUs) assigned as they do not describe a specific procedure or service. It will be necessary to work with your payor to establish payment rates in advance of the procedure. Establishing the value of the procedure relative to another procedure often is the best way to facilitate claim adjudication.

Payors will manually price services based on the documentation provided. **Most payors will review documentation submitted by the provider as well as information on comparable procedures to establish payment for an unlisted code.** In those instances where an unlisted procedure code is reported without prior authorization (for example, traditional Medicare), a copy of the operative report should be submitted, along with supporting information outlining the decision-making process and the

medical rationale for performing the operation. For Medicare patients, this documentation should be submitted to the appropriate Medicare Administrative Contractor (MAC).

When submitting an unlisted procedure code, a concise description of the procedure should be included in Item 19 of the CMS-1500 paper form or its equivalent on an electronic media claim (EMC) form. Providers are encouraged to review the remittance advice for payment as claims are adjudicated.

How to Price an Unlisted Procedure

Once you have determined that the unlisted code is the only appropriate coding solution, you need to find a comparable code that is not an unlisted code. You should base the fee you are going to charge on this comparable code. For example, if the comparison code charge is $2,000, and the amount of work the provider documented was 50% greater, the procedure could be priced at $3,000.

Use the freeform field of the claim form (61 characters in length) to present a crosswalk to another procedure believed to be fairly equivalent, or to offer a comparison to a code for which there is an existing valuation. For example, “XXX99 (unlisted code) comparable to XXXXX, payment of $XXX.XX expected.” It is important to recognize that payors will commonly make the payment decision based on their fee schedule and documentation - not necessarily the submitted charge.

Key aspects of unlisted CPT code reimbursement

- **Documentation is Crucial:**
  Thorough documentation is essential. This includes a clear description of the procedure, the reason it was performed, and any extenuating circumstances. **Do not provide vague or nonspecific documentation.**
- **Comparison to Existing Codes:**
  When possible, compare the unlisted procedure to a similar, existing CPT code to help establish the work and value of the service. **Do not choose a comparable procedure that does not reflect a similar approach or technique.**
- **Payors Determine Payment:**
  Payors will review the documentation and determine the appropriate reimbursement amount based on the submitted information and the comparator code.
- **Potential for Denial:**
  Claims submitted without proper documentation, or when an appropriate specific CPT code exists, may be denied.
- **Work with Payors:**
  Contact payors in advance to discuss the procedure and establish payment expectations, especially for complex or new procedures, according to Upvio.

Physician (continued)

Comparator Codes

For CPT comparator purposes for the ACES System, we recommend cross walking CPT codes 32556 and 49418 (see Coding Option 2). The table below identifies the 2026 Work and Total RVUs for CPT codes 32556 and 49418, as well as the Physician Time for each of the procedures.

The crosswalk procedure selected, should be very near similar to an existing procedure in terms of physician time, training, work, intensity, etc. It is critical to involve your physician in the selection of an unlisted code and appropriate crosswalk comparator.

Potential comparator codes for consideration				Physician Time File (CMS-1832F Work Time 30OCT25)					
CPT Code	**Description**	**Work RVUs**	**Total RVUs (Facility)**	**Pre_ Eval Time**	**Pre_ Positioning_time**	**Pre_Service Scrub_DressWait_tim**	**Median_ Intra_Service_Time**	**Immediate post_Service_time**	**Total Time**
Potential combination codes for unlisted code crosswalk									
49418	Insertion of tunneled intraperitoneal catheter, complete procedure, inc imaging guidance, catheter placement, contrast injection, radiological supervision and interpretation, percutaneous	3.96	5.92	23	6	5	40	20	94
32556	Pleural drainage, perc, with insertion of indwelling catheter**; without** imaging guidance	2.50	3.69	13	3	6	20	18	60
Potential stand-alone code for unlisted code crosswalk									
36563	Insertion of tunneled centrally inserted central venous access device w subcutaneous pump	5.90	31.20	10	10	10	60	15	140

References

[1] Medicare Inpatient Prospective Payment System FY2026 Final Rule, Table 5.

[2] Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. CY2026 Final Rule. OPPS Addendum B, 11212025. APC Status Indicator J1 = All procedures performed on same day as J1 procedure are packaged with highest paying J1 code

[3] CMS Change Request 14223. Sept. 22, 2025. https://www.cms.gov/files/document/r13425cp.pdf.

[4] Medicare Physician Fee Schedule (MPFS) based on Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for CY 2026, Addendum B, MPFS 2026, conversion factor $33.4009 (Non-APM).

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Resources

https://www.aapc.com/blog/91735-unlisted-but-not-unpaid/?srsltid=AfmBOooOo4jgGUWpXM2qms6UrIVWnHVokVZVNKP0c-rdlWfflhcIIR6k.

https://www.hopkinsmedicine.org/-/media/johns-hopkins-health-plans/documents/policies/unlisted-codes-professional.pdf.

https://med.noridianmedicare.com/web/jfa/topics/claim-submission/unlisted-code-billing.

Pleural Dynamics website. https://www.pleuraldynamics.com/

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This information is provided by Pleural Dynamics as a guide for coding Facility and Physician services involving the ACES™ System and is not intended to increase or maximize reimbursement by any payor. Consult your payor organizations with regard to local coverage, coding and reimbursement policies. Providers assume responsibility for all reimbursement decisions or actions. The codes listed in this guide are options only and not intended to drive coding or reimbursement.