



ACES[®] System

(Automatic Continuous Effusion Shunt)

Coding and Reimbursement Guide

(January 2026)

Coding, coverage and payment information for the ACES[™] System to support accurate and efficient claims submission.

Table of Contents

-  **1 Introduction**
Purpose of this guide and important information
-  **2 Hospital Outpatient Guide**
HCPCS, coding and payment for Medicare Traditional
-  **3 Hospital Inpatient Guide**
ICD-10 diagnosis and procedure codes, MS-DRGs and payment
-  **4 Physician Guide**
CPT coding and key reimbursement considerations



Reimbursement Hotline
763-349-1649



Email our Reimbursement Team
Reimbursement@pleuraldynamics.com



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1 | Introduction

About this Guide

Pleural Dynamics provides this coding and reimbursement guide for the FDA-cleared ACES[®] System (Automatic Continuous Effusion Shunt). ACES is a one-piece, fully implanted system designed to use normal breathing motion to move pleural effusion fluid from the chest to the abdomen for reabsorption by the body.

This guide summarizes coding and payment considerations for hospital outpatient, hospital inpatient, and physician services. Medicare guidance is referenced unless otherwise indicated; other payers may apply different requirements.

Reimbursement Support

Reimbursement Hotline: 763-349-1649

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Disclaimer

This guide is provided by Pleural Dynamics for reimbursement informational purposes only. It does not direct which codes or modifiers to use for a particular service, influence clinical judgment, or guarantee coverage or payment. Coding, coverage, and payment information is drawn from various sources and may change without notice. Providers are responsible for determining medical necessity, selecting the appropriate site of service, and submitting accurate codes, charges, and modifiers supported by the services performed and medical record. Consult applicable Medicare guidance, payer policies, reimbursement specialists, or legal counsel as appropriate. Payer decisions and payment remain subject to plan requirements and claim review.

2 | Hospital Outpatient

Traditional Medicare (OPPS)

CMS established HCPCS C8006 effective October 1, 2025, for insertion of a pleural-peritoneal shunt with an intercostal pump chamber. For 2026, C8006 is assigned to APC 5342.

HCPCS	Description	APC ³ / Status	Payment ²
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	\$6,614

J1 denotes comprehensive APC packaging; other same-day services may be packaged, subject to CMS rules and exceptions.

Medicare Advantage and Commercial Plans

Coverage criteria, prior authorization requirements, and reimbursement policies may vary by health plan and provider contract. Before scheduling, verify the patient's benefits, applicable coverage criteria, and any required prior authorization or predetermination directly with the health plan. Authorization does not guarantee payment.

If a Commercial or Medicare Advantage health plan does not allow reporting of HCPCS code C8006, please contact the Pleural Dynamics Reimbursement Team at Reimbursement@pleuraldynamics.com or call 763-349-1649 for assistance with payer-specific coding and reimbursement considerations.

Best Practice Facility Billing Checklist (this list may not be all-inclusive)

- ☐ Train coding and billing staff on code selection and claim submission.
- ☐ Confirm C8006 is configured in the chargemaster with the appropriate revenue code.
- ☐ Price HCPCS code C8006 to ensure that when the hospital's CCR is applied, it accurately reflects the cost of providing the service.
- ☐ Confirm documentation on medical necessity and obtain any prior authorization or predetermination number to add to the claim.
- ☐ Monitor Compliance Metrics by tracking denials, remittance advice, and payer follow-up.

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3 | Hospital Inpatient

Possible Diagnosis and Procedure Coding

Use documented clinical findings and the applicable FY2026 ICD-10-CM and ICD-10-PCS code sets.

ICD-10-CM Diagnosis Code

Type	Code	Description
Diagnosis	J90	Pleural effusion, not elsewhere classified

ICD-10-PCS Procedure Codes

Type	Code	Description
ICD-10-PCS	0W190JG	Bypass right pleural cavity to peritoneal cavity, synthetic substitute, open
ICD-10-PCS	0W1B0JG	Bypass left pleural cavity to peritoneal cavity, synthetic substitute, open
ICD-10-PCS	0W193JG	Bypass right pleural cavity to peritoneal cavity, synthetic substitute, percutaneous
ICD-10-PCS	0W1B3JG	Bypass left pleural cavity to peritoneal cavity, synthetic substitute, percutaneous

FY2026 Medicare Inpatient Payment

Under the Inpatient Prospective Payment System (IPPS), MS-DRG payment generally includes device costs. Final DRG assignment depends on the complete record.

Possible DRG for The ACES System When Primary Diagnosis is Malignant Pleural Effusion

MS-DRG	Description	FY2026 Base Rate ¹
180	Respiratory neoplasms with MCC	\$12,851
181	Respiratory neoplasms with CC	\$7,793
182	Respiratory neoplasms without CC/MCC	\$5,414

Possible DRG for The ACES System

MS-DRG	Description	FY2026 Base Rate ¹
186	Pleural effusion with MCC	\$11,341
187	Pleural effusion with CC	\$7,197
188	Pleural effusion without CC/MCC	\$5,219

Possible DRG for The ACES System + Thoracoscopy and/or Biopsy

MS-DRG	Description	FY2026 Base Rate ¹
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

4 | Physician Services

Possible CPT Codes and Medicare Physician Fee Schedule (MPFS)

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.

No single CPT code describes the implant procedure of the ACES System. The combination of CPT codes 49418 and 32556 may be considered to report the implant procedure, when supported by documentation. A modifier may be applicable depending on the services performed and payer requirements.

CPT	Description	Work RVUs	Facility ⁴	Non-facility ⁴
49418	Insertion of tunneled intraperitoneal catheter (e.g., 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

- Actual payment varies by locality, site of service, modifiers, and payer rules.
- Facility payment is made when the physician performs the procedure in a facility setting such as a hospital.
- Non-facility payment is made when the physician performs the procedure or service in an office or freestanding facility; payment is higher in this setting to account for overhead costs, personnel, supplies, and other practice expenses.
- Multiple procedure reduction may apply: the highest-paying procedure is generally paid at 100%, and eligible secondary procedures at 50%, subject to Medicare rules and applicable exceptions.

Medical Necessity Documentation

Document the diagnosis, symptoms, clinical findings, severity, impact on daily activities, previous treatments and outcomes, and why the ACES procedure is the appropriate next option for this patient.

Before Submitting the Claim

Confirm that the operative report supports each reported code and modifier. Verify payer-specific coverage, medical necessity, and any prior authorization or predetermination requirements.

References

1. Medicare Inpatient Prospective Payment System (IPPS) FY2026 Final Rule, Table 5.
<https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps>
2. Medicare Hospital Outpatient Prospective Payment System (OPPS)/ASC CY2026 Final Rule, OPPS Addendum B.
<https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient>
3. CMS Change Request 14223, September 22, 2025. <https://www.cms.gov/files/document/r13425cp.pdf>
4. CY2026 Medicare Physician Fee Schedule (MPFS), Addendum B. <https://www.cms.gov/medicare/payment/fee-schedules/physician>

Resources

Pleural Dynamics: <https://www.pleuraldynamics.com/>

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