



The Aliya[®] PEF System

2026 Reimbursement & Coding Guide for
Percutaneous and Open Aliya Procedures

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BACKGROUND

ABOUT ALIYA SYSTEM FOR PULSED FIELD ABLATION OF SOFT TISSUE

The Aliya® system is designed to ablate soft tissue through the delivery of pulsed electric fields (PEF) energy to target tissue. The high frequency, short duration energy is delivered to the target tissue to induce cell death while maintaining the extracellular matrix.

INDICATIONS FOR USE

The Aliya® system is 510(k) cleared in the United States for the surgical ablation of soft tissue.

DISCLAIMER

Galvanize Therapeutics® does not promote the off-label use of its products and nothing herein is intended to promote an off-label use of the Aliya System. The Aliya System is a tool for the surgical ablation of soft tissues, and is not intended to treat, cure, prevent or mitigate any specific disease or condition.

The information provided contains general reimbursement information and is presented for illustrative purposes. The information does not constitute reimbursement or legal advice. It is the provider's sole responsibility to determine medical necessity, the proper site for delivery of any services, and to submit accurate and appropriate codes, charges and modifiers based on the services rendered and the patient's medical condition. It is also the provider's sole responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other specific payer billing requirements established by relevant payers. Payer billing, coding and coverage requirements vary from payer to payer, may be updated frequently, and should be verified before treatment for limitations on diagnosis, coding, or service requirements. Galvanize Therapeutics recommends you consult with payers, reimbursement specialists, and/or legal counsel regarding all coding, coverage, and reimbursement matters. **All coding and billing submissions to the federal government and any other payer must be truthful and not misleading, and require full disclosure for the reimbursement of any service or procedure.** Galvanize Therapeutics specifically disclaims any responsibility for actions or consequences resulting from the use of this information.

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DISCLOSURE

Prior to using the Aliya System, please review the Instructions for Use for a complete listing of indications, contraindications, warnings, precautions and potential adverse events. For full prescribing information, please visit www.galvanizetherapeutics.com.

PHYSICIAN, HOSPITAL OUTPATIENT, AND ASC CODING

(JAN 1, 2026 to DEC 31, 2026)

Medicare 2026 National Amounts (Before Geographic Adjustment)								
Service Provided		Physician ¹		Hospital Outpatient ²			ASC ³	
CPT [®]	Description	Non-Facility	Facility	APC	Status Indicator	APC Rate	ASC Rate	Payment Indicator
0600T*	Ablation, irreversible electroporation; 1 or more tumors per organ, other than liver or prostate, including imaging guidance, when performed, percutaneous	No national payment established		5362	J1	\$10,860.07	\$7,609.75	J8
0601T*	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open	No national payment established		5362	J1	\$10,860.07	\$7,534.33	J8
47384	Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous	NA	\$424.19	5362	J1	\$10,860.07	\$7,609.75	J8
55877	Ablation, irreversible electroporation, prostate, 1 or more tumors, including imaging guidance, percutaneous	NA	\$671.36	5362	J1	\$10,860.07	\$7,534.33	J8

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HOSPITAL SUPPLY CODING

(Aliya Electrode and Percutaneous Needle)

HCPCS Code	Description	Status Indicator	Ambulatory Payment Classification (APC)	2026 Medicare National Amount
C1889	Implantable/injectable device, not otherwise classified	N	NA	NA

Category III CPT[®] Codes

The Aliya PEF procedure may be reported using the Category III CPT[®] codes in the table above. These codes specifically describe irreversible electroporation (IRE) of tumors via a percutaneous or open approach. If any other type of laproscopic, endoscopic, or bronchoscopic approach is performed, an unlisted procedure code may be reported. Unlisted CPT[®] codes or “not otherwise specified” CPT[®] codes allow physicians to report procedures that do not have a specific CPT[®] code, and require appropriate supporting documentation. The procedures described by Category III CPT[®] 0600T and 0601T include imaging guidance procedures. Imaging guidance CPT codes are not separately reported with 0600T or 0601T.

Category III CPT[®] Codes are temporary codes for emerging technology, services and procedures that allow for specific data collection associated with those services and procedures. According to the AMA CPT[®], if a Category III code is available, it must be reported instead of a Category I unlisted code¹.

There are no assigned RVUs or established physician payment amounts for Category III CPT® codes. Reimbursement to the physician is at the payer's discretion. Payers that have implemented the new Category III IRE codes may request documentation of clinical efficacy to support coverage. The following items are recommended to support your claim submissions:

- Copy of operative report
- Letter of medical necessity
- Copy of the Aliya FDA clearance letter

When submitting a claim with a Category III CPT® code, it is recommended that providers submit a letter for the Category III CPT service that compares the service to one or more existing Category I CPT codes to support an estimate of RVUs and requested charge amount for the reported Category III CPT code. The procedure described by the Category III CPT code may be more complex, similar to or less complex and may require more, the same or less physician time than the comparator Category I CPT codes. This comparison is used to document the estimated RVUs and requested charges for the reported Category III CPT code.

INPATIENT HOSPITAL CODING

(OCT 1, 2025 to SEP 30, 2026)

THE CODES BELOW DO NOT PRESUME, ASSUME, OR INTEND TO PROMOTE THE USE OF THIS GENERAL TOOL IN ANY SPECIFIC ANATOMICAL LOCATION OR FOR ANY SPECIFIC TREATMENT BY THE HEALTHCARE PROVIDER. THIS REIMBURSEMENT GUIDE IS ONLY INTENDED TO IDENTIFY GENERAL SOFT TISSUE LOCATIONS.

KIDNEY ICD-10-PCS CODES AND MS-DRGS

The table below lists example ICD-10-PCS codes that may be reported for kidney ablation procedures performed in the hospital inpatient setting.

ICD-10-PCS Code	Description*
0T500ZZ	Destruction of right kidney, open approach
0T503ZZ	Destruction of right kidney, percutaneous approach
0T504ZZ	Destruction of right kidney, percutaneous endoscopic approach
0T510ZZ	Destruction of left kidney, open approach
0T513ZZ	Destruction of left kidney, percutaneous approach
0T514ZZ	Destruction of left kidney, percutaneous endoscopic approach
0T530ZZ	Destruction of right kidney pelvis, open approach
0T533ZZ	Destruction of right kidney pelvis, percutaneous approach
0T534ZZ	Destruction of right kidney pelvis, percutaneous endoscopic approach
0T540ZZ	Destruction of left kidney pelvis, open approach
0T543ZZ	Destruction of left kidney pelvis, percutaneous approach
0T544ZZ	Destruction of left kidney pelvis, percutaneous endoscopic approach

Medicare Severity Diagnosis Related Groups (MS-DRGs)^{5,6}

The following MS-DRGs may apply to kidney ablation procedures for Medicare patients.

MS-DRG ⁵	MS-DRG Title	Relative Weight	Hospital Payment
656	Kidney and ureter procedures for neoplasm w/ MCC	3.1838	\$23,167.75
657	Kidney and ureter procedures for neoplasm w/ CC	1.8300	\$13,316.47
658	Kidney and ureter procedures for neoplasm w/o CC/MCC	1.5518	\$11,292.08
659	Kidney and ureter procedures for non-neoplasm w/ MCC	2.5409	\$18,489.52
660	Kidney and ureter procedures for non-neoplasm w/ CC	1.3217	\$9,617.69
661	Kidney and ureter procedures for non-neoplasm w/o CC/MCC	1.0354	\$7,534.36

ICD-10-CM⁷ Diagnosis Codes

The listed ICD-10-CM diagnosis codes are examples of codes that may be reported with kidney ablation procedures. This list is not intended to be comprehensive nor exhaustive. Other secondary diagnosis codes corresponding to additional conditions at the time of admission or developing subsequently, and having an effect on the procedures performed or length of stay during the same inpatient admission, may also be reported.

ICD-10-CM Code	Description
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

LIVER ICD-10-PCS CODES AND MS-DRGS

ICD-10-PCS Codes

The table below lists example ICD-10-PCS codes that may be reported for liver ablation procedures performed in the hospital inpatient setting.⁴

ICD-10-PCS Code	Description ⁴
0F500ZF	Destruction of liver using irreversible electroporation, open approach
0F503ZF	Destruction of liver using irreversible electroporation, percutaneous approach
0F504ZF	Destruction of liver using irreversible electroporation, percutaneous endoscopic approach
0F510ZF	Destruction of right lobe liver using irreversible electroporation, open approach
0F513ZF	Destruction of right lobe liver using irreversible electroporation, percutaneous approach
0F514ZF	Destruction of right lobe liver using irreversible electroporation, percutaneous endoscopic approach
0F520FZ	Destruction of left lobe liver using irreversible electroporation, open approach
0F523FZ	Destruction of left lobe liver using irreversible electroporation, percutaneous approach
0F524FZ	Destruction of left lobe liver using irreversible electroporation, percutaneous endoscopic approach

Medicare Severity Diagnosis Related Groups (MS-DRGs)^{5,6}

The following MS-DRGs may apply to liver ablation procedures for Medicare patients.

MS-DRG ⁵	MS-DRG Title	Relative Weight	Hospital Payment
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 and shunt procedures w/ MCC	5.4705	\$39,807.52
406	Pancreas, liver and shunt procedures w/ CC	2.9002	\$21,104.06
407	Pancreas, liver and shunt procedures w/o CC/MCC	2.2196	\$16,151.50

ICD-10-CM⁷ Diagnosis Codes)

The listed ICD-10-CM diagnosis codes are examples of codes that may be reported with liver ablation procedures. This list is not intended to be comprehensive nor exhaustive. Other secondary diagnosis codes corresponding to additional conditions at the time of admission or developing subsequently, and having an effect on the procedures performed or length of stay during the same inpatient admission, may also be reported.

ICD-10-CM Code	Description
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
D01.5	Carcinoma in situ of liver, gallbladder and bile ducts

LUNG ICD-10-PCS CODES AND MS-DRGS

ICD-10-PCS Codes

The table below lists example ICD-10-PCS codes that may be reported for lung ablation procedures performed in the hospital inpatient setting.⁴

ICD-10-PCS Code	Description*
0B533ZZ	Destruction of Right Main Bronchus, Percutaneous Approach
0B543ZZ	Destruction of Right Upper Lobe Bronchus, Percutaneous Approach
0B553ZZ	Destruction of Right Middle Lobe Bronchus, Percutaneous Approach
0B563ZZ	Destruction of Right Lower Lobe Bronchus, Percutaneous Approach
0B573ZZ	Destruction of Left Main Bronchus, Percutaneous Approach
0B583ZZ	Destruction of Left Upper Lobe Bronchus, Percutaneous Approach
0B593ZZ	Destruction of Lingula Bronchus, Percutaneous Approach
0B5B3ZZ	Destruction of Left Lower Lobe Bronchus, Percutaneous Approach
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
0B5T3ZZ	Destruction of Diaphragm, Percutaneous Approach
0B5_0ZZ	Destruction of [see above], Open Approach

Medicare Severity Diagnosis Related Groups (MS-DRGs)^{5,6}

The following MS-DRGs may apply to lung ablation procedures for Medicare patients.

MS-DRG*	MS-DRG Title	Relative Weight	Hospital Payment
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 respiratory system O.R. procedures w/MCC	3.7377	\$27,198.35
167	Other respiratory system O.R. procedures w/ CC	1.8034	\$13,122.91
168	Other respiratory system O.R. procedures w/o CC/MCC	1.3664	\$9,942.96

ICD-10-CM⁷ Diagnosis Codes

The listed ICD-10-CM diagnosis codes are examples of codes that may be reported with lung ablation procedures. This list is not intended to be comprehensive nor exhaustive. Other secondary diagnosis codes corresponding to additional conditions at the time of admission or developing subsequently, and having an effect on the procedures performed or length of stay during the same inpatient admission, may also be reported.

ICD-10-CM Code	Description ⁴
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, unspecified bronchus or lung
C34.81	Malignant neoplasm of overlapping sites, right bronchus or lung
C34.82	Malignant neoplasm of overlapping sites, left bronchus or lung
C34.90	Malignant neoplasm of unspecified part, unspecified bronchus or lung
C34.91	Malignant neoplasm of unspecified part, right bronchus or lung
C34.92	Malignant neoplasm of unspecified part, left bronchus or lung
C37	Malignant neoplasm of thymus
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
C7A.090	Malignant carcinoid tumor of the bronchus and lung
C7A.091	Malignant carcinoid tumor of the thymus
D02.20	Carcinoma in situ of unspecified bronchus and lung
D02.21	Carcinoma in situ of right bronchus and lung
D02.22	Carcinoma in situ of left bronchus and lung
D38.1	Neoplasm of uncertain behavior of trachea, bronchus and lung
D38.2	Neoplasm of uncertain behavior of pleura
D38.3	Neoplasm of uncertain behavior of mediastinum
D38.4	Neoplasm of uncertain behavior of thymus

PANCREAS ICD-10-PCS CODES AND MS-DRGS

ICD-10-PCS Codes

The table below lists example ICD-10-PCS codes that may be reported for pancreas ablation procedures performed in the hospital inpatient setting.⁴

ICD-10-PCS Code	ICD-10-PCS Description ⁴
0F5G0ZF	Destruction of pancreas using irreversible electroporation, open approach
0F5G3ZF	Destruction of pancreas using irreversible electroporation, percutaneous approach
0F5G4ZF	Destruction of pancreas using irreversible electroporation, percutaneous endoscopic approach

Medicare Severity Diagnosis Related Groups (MS-DRGs)^{5,6}

The following MS-DRGs may apply to pancreas ablation procedures for Medicare patients.

MS-DRG ⁵	MS-DRG Description	Relative Weight	Hospital Payment
405	Pancreas, liver and shunt procedures w/ MCC	5.4705	\$39,807.52
406	Pancreas, liver and shunt procedures w/ CC	2.9002	\$21,104.06
407	Pancreas, liver and shunt procedures w/o CC/MCC	2.2196	\$16,151.50
628	Other endocrine, nutritional and metabolic O.R. procedure w/ MCC	3.7268	\$27,119.03
629	Other endocrine, nutritional and metabolic O.R. procedure w/ CC	2.1788	\$15,854.60
630	Other endocrine, nutritional and metabolic O.R. procedure w/o CC/MCC	1.4595	\$10,620.43

ICD-10-CM⁷ Diagnosis Codes

The listed ICD-10-CM diagnosis codes are examples of codes that may be reported with pancreas ablation procedures. This list is not intended to be comprehensive nor exhaustive. Other secondary diagnosis codes corresponding to additional conditions at the time of admission or developing subsequently, and having an effect on the procedures performed or length of stay during the same inpatient admission, may also be reported.

ICD-10-CM Code	Description
C25.0	Malignant neoplasm of head of pancreas
C25.1	Malignant neoplasm of body of pancreas
C25.2	Malignant neoplasm of tail of pancreas
C25.3	Malignant neoplasm of pancreatic duct
C25.4	Malignant neoplasm of endocrine pancreas
C25.7	Malignant neoplasm of other parts of pancreas
C25.8	Malignant neoplasm of overlapping sites of pancreas
C25.9	Malignant neoplasm of pancreas, unspecified

REIMBURSEMENT SUPPORT

For questions regarding coding, coverage, payment and other reimbursement information, please contact us at: AliyaReimbursement@galvanizetx.com.

REIMBURSEMENT TERMINOLOGY

Term	Description
CMS	Centers for Medicare and Medicaid Services
ASC	Ambulatory Surgical Center
OPPS	Outpatient Prospective Payment System
APC	Ambulatory Payment Classification
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; rehabilitation therapy services; services assigned to a new technology APC; self-administered drugs; all preventive services; and certain Part B inpatient services.
J8	Device-intensive procedure; paid at adjusted rate
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
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.
Relative Weight	A numeric value that reflects the relative resource consumption for the DRG to which it is assigned

Sources:

1. CMS Physician Fee Schedule. CMS-1832-F. Rates shown for non-qualifying Alternative Payment Model (APM) participant. If the physician is not a Qualifying Participant in an APM, Conversion Factor \$33.4009 applies. If the physician is a Qualifying Participant in an APM, Conversion Factor \$33.5675 applies. <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f>. Accessed January 2, 2026.
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4. CMS, 2026 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/icd10m/FY2026-nprm-version43-fullcode-cms/fullcode_cms/P0001.html. Accessed January 2, 2026.
5. CMS, 2026 ICD-10-CM/PCS MS-DRG v43, Definitions Manual. https://www.cms.gov/icd10m/FY2026-nprm-version43-fullcode-cms/fullcode_cms/P0001.html. Accessed January 2, 2026.
6. CMS, [CMS-1833-F] Fiscal Year (FY)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>. Accessed January 2, 2026. Medicare national base MS-DRG payment amounts calculated using standardized amounts in Tables 1A-1E (for urban areas) and assume that the hospital has submitted quality data and is a Meaningful EHR user. Academic teaching and disproportionate share hospitals may qualify for additional payment amounts in addition to the base MS-DRG. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the final hospital-specific base payment amount.
7. Centers for Disease Control and Preventions (CDC), National Center for Health Statistics (NCHS). International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). <https://www.cdc.gov/nchs/icd/icd-10-cm/files.html>. Accessed January 2, 2026.



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