ABBOTT CODING GUIDE

CORONARY ARTERY CHRONIC TOTAL OCCLUSION (CTO)
2019 MEDICARE REIMBURSEMENT

CODING AND PAYMENT FOR CTO

Physician Fee Schedule

The following tables highlight the differences in physician fee schedule and hospital payments for CTOs from 2016 to 2019.

CPT‡ CODE	DESCRIPTION	FINAL RULE BASE PAYMENT				2016-2019 % CHANGE
		CY 2019[1]	CY 2018[2]	CY 2017[3]	CY 2016[4]	
92943	CTO with BMS or DES stent	$698	$696	$695	$707	-1.27%

Physician References

1. CY 2019 Physician Fee Schedule Final Rule; Centers for Medicare and Medicaid Services. Available at - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html
2. CY 2018 Physician Fee Schedule Final Rule; Centers for Medicare and Medicaid Services. Available at -https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-P.html
3. CY 2017 Physician Fee Schedule Final Rule; Centers for Medicare and Medicaid Services. Available at - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-CN4.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending;
4. CY 2016 Physician Fee Schedule Final Rule; Centers for Medicare and Medicaid Services. Available at - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1631-FC.html

CODING AND PAYMENT FOR CTO

Outpatient Fee Schedule

The following tables highlight the differences in physician fee schedule and hospital payments for CTOs from 2016 to 2019.

C-APC*	DESCRIPTION	FINAL RULE BASE PAYMENT				2016-2019 % CHANGE
		CY 2019[1]	CY 2018[1]	CY 2017[1]	CY 2016[1]	
5193	Level III Endovascular Procedures - Includes CPT‡ code 92943 (PTCA of a CTO treated with a BMS)[2]	$9,669	$10,510	$9,752	$9,542	1%
5194	Level IV Endovascular Procedures - Includes HCPCS C9607 (PTCA of a CTO treated with a DES)[3]	$15,355	$16,020	$14,782	$14,612	5%

Establishment of Comprehensive APCs

In an effort to create incentives for hospitals to provide efficient and high-quality care at lower cost, CMS implemented a policy finalized regarding comprehensive Ambulatory Payment Classifications (C-APCs). A C-APC is an APC with a high-cost primary service that generally includes the implantation of a device. The C-APC payment policy will consider the entire hospital stay, defined as all services reported on the hospital claim, to be one comprehensive service. This results in a single Medicare payment and a single beneficiary copayment under the OPPS for the comprehensive service based on all included charges on the claim. CMS is finalizing the C-APC policy for 25 C-APCs.

Outpatient References

1. Centers of Medicare and Medicaid Services. Addendum A and Addendum B Updates. Available at - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html
2. CPT 92943 - Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel
3. HCPCS C9607 - Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel

CODING AND PAYMENT FOR CTO

Inpatient Fee Schedule

The following table highlights the differences in inpatient payments for CTOs from 2016 to 2019.

DRG	DESCRIPTION	FINAL RULE BASE PAYMENT				2016-2019 % CHANGE
		FY 2019[1]	FY 2018[2]	FY 2017[3]	FY 2016[4]	
246	Percutaneous Cardiovascular Procedure with Drug-eluting Stent with MCC or 4+ more vessels/stents	$19,787	$19,352	$19,396	$19,191	3.11%
247	Percutaneous Cardiovascular Procedure with Drug-eluting Stent without MCC	$12,690	$12,754	12,658	$12,584	0.84%
248	Percutaneous Cardiovascular Procedure with Non Drug-eluting Stent with MCC or 4+ more vessels/ stents	$19,382	$18,373	$18,156	$18,129	6.91%
249	Percutaneous Cardiovascular Procedure with Non Drug-eluting Stent without MCC	$12,158	$11,797	$11,544	$11,304	7.55%

Inpatient References

1. Centers of Medicare and Medicaid Services. FY 2019 IPPS Final Rule Homepage. Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page.html
2. Centers of Medicare and Medicaid Services. FY 2018 IPPS Final Rule Homepage. Available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page.html
3. Centers of Medicare and Medicaid Services. FY 2017 IPPS Final Rule Homepage. Available at - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html;
4. Centers of Medicare and Medicaid Services. FY 2016 IPPS Final Rule Homepage. Available at - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page.html;

CODING AND PAYMENT FOR CTO

Additional Coding Information

CTO Hospital Coding for OPPS and IPPS

C9607 - HCPCS II CTO with DES
C9608 - HCPCS II CTO with DES; Each additional vessel

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