HEALTH ECONOMICS & REIMBURSEMENT

PATENT FORAMEN OVALE (PFO) CODING GUIDE

Hospital Inpatient

Effective October 1, 2026 to September 30, 2027

Hospital Outpatient and Physician

Effective January 1, 2026 to December 31, 2026

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TABLE OF CONTENTS

OVERVIEW

This content is intended to provide reference material related to general guidelines for reimbursement when used consistently with the product's labeling. This content includes information regarding coverage, coding and reimbursement.

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IMPORTANT NOTE

Medicare participation varies by provider. The payment rates shown are the National Average Medicare payment rates. Reimbursement listed may not apply to all institutions despite Medicare participation.

REIMBURSEMENT SUPPORT

REIMBURSEMENT HOTLINE

Abbott offers a reimbursement hotline, which provides live coding and reimbursement information from dedicated reimbursement specialists. Coding and reimbursement assistance is provided subject to the disclaimers set forth in this guide.

8 a.m. to 5 p.m. CT, Monday – Friday
Call (855) 569-6430
Email hce@abbott.com

This content and supporting documents are available at
www.cardiovascular.abbott/us/en/hcp/reimbursement

REIMBURSEMENT FIELD TEAM

To contact a reimbursement specialist for coverage, coding or payment questions, scan the QR code or send an email to abbotteconomics@abbott.com.

HOSPITAL INPATIENT[1]

Effective October 1, 2026 to September 30, 2027

MEDICARE NATIONAL AVERAGE REIMBURSEMENT INFORMATION

PFO procedures are assigned to MS-DRG 273/274: Percutaneous Intracardiac Procedures. The rates in the table below are the national average reimbursement rates. For hospital specific rates, please contact your local Abbott representative.

TYPICAL MS-DRG	MEDICARE RATE
273 with MCCs	$31,761
274 without MCCs	$24,620

PROCEDURE CODES[2]

ICD-10-PCS CODE	DESCRIPTION
02U53JZ	Supplement atrial septum with synthetic substitute, percutaneous approach

HOSPITAL OUTPATIENT[3] & PHYSICIAN[4]

Effective January 1, 2026 to December 31, 2026

		HOSPITAL OUTPATIENT			PHYSICIAN	
CPT‡ CODE[5]	DESCRIPTION	SI	APC	APC RATE	WORK RVU	FACILITY RATE
PATENT FORAMEN OVALE						
93580	Percutaneous transcatheter closure of congenital interatrial communication (i.e., fontan fenestration, atrial septal defect) with implant	J1	5194	$18,729	17.30	$844

PROCEDURAL IMAGING		HOSPITAL OUTPATIENT			PHYSICIAN	
CPT‡ CODE[5]	DESCRIPTION	SI	APC	APC RATE	WORK RVU	FACILITY RATE
TRANSESOPHAGEAL ECHOCARDIOGRAPHY (TEE)**						
93355**	Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to the code for primary procedure	NA	NA	NA	4.54	$192
INTRACARDIAC ECHOCARDIOGRAPHY (ICE)						
+93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	NA	NA	NA	1.40	$69

J1: Hospital Part B services paid through a comprehensive APC
SI: Status indicator
(+) = Indicates add-on code. List add-on code separately in addition to code for primary procedure.
* Note that 93355 is bundled and not separately payable when reported on the same physician claim as the primary procedure or with anesthesia services[6]
NA There is no established Medicare payment in this setting

ADDITIONAL CODES

Effective January 1, 2026 to December 31, 2026

HCPCS DEVICE CATEGORY C-CODES[7]

C-CODES	DESCRIPTION
C1817	Septal defect implant system, intracardiac
C1769	Guide wire

ICD-10-CM DIAGNOSIS CODES[8]

ICD-10-CM CODES	DESCRIPTION
Q21.1	Atrial septal defect
Q21.12	Patent Foramen Ovale

While there are no ICD-10-CM diagnosis codes to specifically describe cryptogenic stroke (CS) as a secondary condition, there is only one generic ICD-10-CM diagnosis code for ischemic stroke with no specification as to the type of the cerebrovascular condition which could be used for reporting of the CS:

- I63.9, Cerebral infarction, unspecified

Claims submission to a majority of U.S. private insurance companies are often driven by the existence of specific coding to explain the services requested. Payers will often require additional information on the claim form, or in addition to the claim form, in order to adjudicate the claims. Documentation requirements may vary by payer, however, at minimum, the following documentation should be provided.

- Description of test results performed to confirm PFO
- Description of test results confirming CS and likelihood of PFO involvement (other causes of stroke should be ruled out)

RESOURCES

CLINICAL DOCUMENTATION CHECKLIST

Diagnosis of cryptogenic ischemic stroke

It is recommended that the comprehensive evaluation follow the latest professional society guidelines for diagnosing a cryptogenic ischemic stroke. The following assessments are identified in the device Instructions for Use (IFU) which should be included in the patient's documentation at a minimum:

DESCRIPTION	INCLUDED
MRI or CT scanning of the head to rule out small vessel disease or lacunar infarct	☐
TEE to rule out non-PFO intra-cardioembolic sources or conditions or aortic arch atheroma	☐
ECG and prolonged cardiac rhythm monitoring (~ 30 days) to rule out atrial fibrillation and other heart rhythm disturbances that may be associated with stroke	☐
Intra and extracranial artery imaging: MRA, CT angiography, or contrast angiography to rule out an ischemic stroke associated with atherosclerotic plaque, arterial dissection or other vascular diseases	☐
Hematological evaluation to rule out underlying hypercoagulable state	☐

This list is not an exhaustive list of all conditions to consider. It is the responsibility of the provider to determine the proper assessments to determine the diagnosis of a cryptogenic stroke.

ACRONYM DEFINITIONS

ACRONYM	DEFINITION
CC	Complications or Comorbidities
CMS	Centers for Medicare & Medicaid Services
MCC	Major Complications or Comorbidities
MS-DRG	Medicare Severity Diagnosis Related Group
NVAF	Non-Valvular Atrial Fibrillation
PFO	Patent Foramen Ovale

REFERENCES

1. Hospital Inpatient Prospective Payment-Final Rule Home Page FY 2027 CMS-1849-F. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2027-ipps-final-rule-home-page
2. CMS 2027 ICD-10-PCS. https://www.cms.gov/files/document/2027-official-icd-10-pcs-coding-guidelines.pdf
3. CMS 2026 Hospital Outpatient Prospective Payment-Final Rule Home Page CMS-1834-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc
4. Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2026. CMS-1832-F. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f
5. CPT‡ Coding Guidelines. American Medical Association. https://www.ama-assn.org/
6. Medicare Claims Processing Manual, Chapter 12, Section 40.8, Section B – Billing instructions. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
7. CMS Alpha-Numeric Index HCPCS code set. https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/alpha-numeric
8. CMS 2027 ICD-10-CM. https://www.cms.gov/medicare/coding-billing/icd-10-codes

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