

Medicare HCPCS C Codes for Reporting Devices on Hospital Outpatient Claims

2011 Edition†



OVERVIEW

CMS (Medicare) requires the reporting of C Codes (device codes) for certain outpatient procedures. A list of current device and procedure edits can be found on the CMS web site http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage. The following tables list the Gore catalogue numbers and applicable C Codes for products that could be used in the Hospital Outpatient Department under ordinary circumstances. These do not represent all Gore products that could potentially be selected by a physician for such use. If a catalogue number does not appear below, or if you have any questions regarding eligibility, contact Customer Service at 800.528.8763.

All products do not have C Codes!

Devices typically utilized for inpatient procedures are not reported with C Codes. Inpatient-only procedures (Status C), are listed in Addendum E of the CY 2011 Hospital Outpatient Final Rule, CMS (see Suggested Resources), “HCPCS codes that would only be payable as inpatient procedures.” Examples of Gore products that do not have C Codes because they are commonly used in conjunction with Status C procedures are provided. This is not an all-inclusive list.

PRODUCTS TYPICALLY USED IN MEDICARE APC STATUS INDICATOR C (INPATIENT ONLY) PROCEDURES

NO C CODE REQUIRED FOR INPATIENT PROCEDURES

Catalogue Number Prefix	Product Description
BW, BK, SB, SBT	Bifurcated Vascular Grafts
PXT, PXC, PXA, PXL PG	GORE® EXCLUDER® AAA Endoprosthesis GORE® Introducer Sheath
RMT	GORE® EXCLUDER® AAA Endoprosthesis featuring the C3 Delivery System
SDV	GORE® DrySeal Sheath (If used in Outpatient use C1894)
Q50	Stent Graft Balloon Catheter (If used in Outpatient use C1725)
TG	GORE® TAG® Thoracic Endoprosthesis
TS	GORE® Introducer Sheath
BC	GORE® Tri-Lobe Balloon Catheter
BCL	GORE® Tri-Lobe Balloon Catheter, Large Enhanced Design
BCM	GORE® Tri-Lobe Balloon Catheter, Small Enhanced Design
1PCM	GORE® PRECLUDE® Pericardial Membrane
1PTM	GORE® PRECLUDE® Peritoneal Membrane
1PDS	GORE® PRECLUDE® Dura Substitute
1MVP	GORE® PRECLUDE® MVP® Dura Substitute
1PDX	GORE® PRECLUDE® PDX Dura Substitute
PVG	GORE® PRECLUDE® Vessel Guard
BSG	GORE® SEAMGUARD® Staple Line Reinforcement

INTERVENTIONAL PRODUCTS

CATEGORY HCPCS: C1874	LONG DESCRIPTOR: STENT COATED / COVERED WITH DELIVERY SYSTEM
Catalogue Number Prefix	Product Description
VB, VBC, VBH	GORE® VIABAHN® Endoprosthesis
VH, VN	GORE® VIABIL® Biliary Endoprosthesis
PTB	GORE® VIATORR® TIPS Endoprosthesis

Example: Catalogue Number VB061501 is Prefix VB

CATEGORY HCPCS: C1725	LONG DESCRIPTOR: CATHETER, TRANSLUMINAL ANGIOPLASTY, NON-LASER (MAY INCLUDE GUIDANCE, INFUSION / PERFUSION CAPABILITY)
Catalogue Number Prefix	Product Description
Q50	Stent Graft Balloon Catheter

CATEGORY HCPCS: C1884	LONG DESCRIPTOR: EMBOLIZATION PROTECTION SYSTEM - FOR CAROTID ARTERY STENTING
Catalogue Number Prefix	Product Description
GFRS	GORE® Flow Reversal System

CATEGORY HCPCS: C1817	LONG DESCRIPTOR: SEPTAL DEFECT IMPLANT SYSTEM, INTRACARDIAC
Catalogue Number Prefix	Product Description
HX	GORE® HELEX Septal Occluder

IMPORTANT: This is an abbreviated list. All Vascular Graft catalogue numbers are eligible for C1768. This list indicates those sizes / configurations most likely to be used in currently approved outpatient procedures.

VASCULAR GRAFTS

CATEGORY HCPCS: C1768

LONG DESCRIPTOR: GRAFT, VASCULAR

Catalogue Number Prefix	Product Description
H06	GORE® PROPATEN® Vascular Graft
H47	GORE® PROPATEN® Vascular Graft
HR	GORE® PROPATEN® Vascular Graft, Fixed Ring
IGK (BK, SK)	<i>Intervascular</i> ® Knitted Vascular Graft (Most of these products will be implanted during an inpatient procedure, which does not require a C Code)
IGW (BW)	<i>Intervascular</i> ® Woven Vascular Graft (Most of these products will be implanted during an inpatient procedure, which does not require a C Code)
IR	GORE® INTERING® Vascular Graft
IRS	GORE® INTERING® Vascular Stretch Graft
IRST	GORE® INTERING® Vascular Stretch Graft, Thin-walled
RD	GORE-TEX® Vascular Grafts, Standard-walled with Rings
R0	GORE-TEX® Vascular Grafts, Standard-walled with Rings
RR	GORE-TEX® Vascular Grafts, Removable Rings
RR47	GORE-TEX® Vascular Grafts, Rapid Taper with Removable Rings
RRT06	GORE-TEX® Vascular Grafts, Thin-walled with Removable Rings
RT06	GORE-TEX® Vascular Grafts, Thin-walled with Rings
S05	GORE-TEX® Stretch Vascular Grafts, Standard-walled
S06	GORE-TEX® Stretch Vascular Grafts, Standard-walled
S07	GORE-TEX® Stretch Vascular Grafts, Standard-walled
S08	GORE-TEX® Stretch Vascular Grafts, Standard-walled
S46	GORE-TEX® Stretch Vascular Grafts, Rapid Taper
S47	GORE-TEX® Stretch Vascular Grafts, Rapid Taper
SR	GORE-TEX® Vascular Grafts, Standard-walled with Rings
SRD	GORE-TEX® Vascular Grafts, Standard-walled with Rings
SR	GORE-TEX® Stretch Vascular Grafts, Standard-walled with Rings
SRD	GORE-TEX® Stretch Vascular Grafts, Standard-walled with Rings
ST06	GORE-TEX® Stretch Vascular Grafts, Thin-walled
ST07	GORE-TEX® Stretch Vascular Grafts, Thin-walled
ST08	GORE-TEX® Stretch Vascular Grafts, Thin-walled
V050	GORE-TEX® Vascular Grafts, Standard-walled
V060	GORE-TEX® Vascular Grafts, Standard-walled
V070	GORE-TEX® Vascular Grafts, Standard-walled
V080	GORE-TEX® Vascular Grafts, Standard-walled
V46	GORE-TEX® Vascular Grafts, Rapid Taper
V47	GORE-TEX® Vascular Grafts, Rapid Taper
VT050	GORE-TEX® Vascular Grafts, Thin-walled
VT060	GORE-TEX® Vascular Grafts, Thin-walled
VT070	GORE-TEX® Vascular Grafts, Thin-walled
VT080	GORE-TEX® Vascular Grafts, Thin-walled

Example: Catalogue Number SRD06005050L is Prefix SRD

HERNIA AND WALL DEFECT REPAIR PRODUCTS

CATEGORY HCPCS: C1781

LONG DESCRIPTOR: MESH, IMPLANTABLE

Catalogue Number Prefix

Product Description

1DLM	GORE® DUALMESH® Biomaterial
1DLMCP	GORE® DUALMESH® PLUS Biomaterial
1DLMCPH	GORE® DUALMESH® PLUS Biomaterial with Holes
1DLMC	GORE® DUALMESH® Biomaterial
1GNF	GORE® INFINIT Mesh
1MYM	GORE® MYCROMESH® Biomaterial
1MYMP	GORE® MYCROMESH® PLUS Biomaterial
FP	GORE® BIO-A Fistula Plug
FS	GORE® BIO-A Tissue Reinforcement
HP	GORE® BIO-A Hernia Plug
1HPGNF04	GORE® BIO-A Hernia Plug with INFINIT Mesh
13"xxx..."; 14"xxx.." (ex. 1305010020)	GORE-TEX® Soft Tissue Patch

CARDIOVASCULAR PATCH

CATEGORY HCPCS: C1768

LONG DESCRIPTOR: GRAFT, VASCULAR

Catalogue Number Prefix

Product Description

1702515006	GORE-TEX® Cardiovascular Patch .6 mm
1702503806	GORE-TEX® Cardiovascular Patch .6 mm
1705007506	GORE-TEX® Cardiovascular Patch .6 mm
1705015006	GORE-TEX® Cardiovascular Patch .6 mm
1710015006	GORE-TEX® Cardiovascular Patch .6 mm
1802009004	GORE-TEX® Cardiovascular Patch .4 mm
1803003004	GORE-TEX® Cardiovascular Patch .4 mm
1803006004	GORE-TEX® Cardiovascular Patch .4 mm
1905007508	GORE-TEX® Cardiovascular Patch .8 mm
1910015008	GORE-TEX® Cardiovascular Patch .8 mm
1CVX	GORE® ACUSEAL Cardiovascular Patch
CP (HEK)	<i>InterVascular</i> ® Collagen Coated Knitted UltraThin® Polyester Vascular Patches

INTRODUCER / SHEATH

CATEGORY HCPCS: C1894

LONG DESCRIPTOR: INTRODUCER / SHEATH OTHER THAN GUIDING, OTHER THAN INTRACARDIAC, ELECTROPHYSIOLOGICAL, NON-LASER

Catalogue Number Prefix

Product Description

SDV	GORE® DrySeal Sheath
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OTHER PRODUCTS

CATEGORY HCPCS: C1878

LONG DESCRIPTOR: MATERIAL FOR VOCAL CORD MEDIALIZATION, SYNTHETIC (IMPLANTABLE)

Catalogue Number Prefix

Product Description

MTD	GORE® Thyroplasty Device
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Example: Catalogue Number 1MTD20 1 is Prefix MTD

TERMINOLOGY AND ACRONYMS

ABN: Advance Beneficiary Notice. A legal, written notice to a Medicare beneficiary from a physician or hospital informing the patient that the health service or item that the physician has prescribed is not or may not be a covered service under Medicare, and that the patient will be responsible for payment if denied.

Anesthesia Guidelines: The rules for coding and charging are complex. Variable circumstances can include duration, method of anesthesia / sedation, the physician or specialist administering services, and the site of service. Local Medicare Policies, and the AMA CPT® coding book, professional edition, should be consulted for questions regarding the proper coding and billing for anesthesia services.

APC: Ambulatory Payment Classification. These are numeric classifications used by Medicare to reimburse services performed in a hospital outpatient setting. An APC will contain multiple HCPCS Codes that are similar both clinically and in terms of resources used by the hospital. The APC rate is set prospectively by CMS based on historic claims data.

APC Status Indicator: Alpha characters are used to designate the APC payment calculation method. For multiple APCs on a single claim with Status Indicator "T" the first APC will be paid at 100% and all others at 50%. For all APCs with Status Indicator "S" each APC will be paid at 100%, no discounting.

ASC: Ambulatory Surgery Center. When used by Medicare, this designation describes a legal licensing status establishing a site of service distinct from a physician's office or hospital-based facility.

Bundled: Certain supplies / procedures provided by a physician as described by CPT® Codes / HCPCS Codes may be included ("Bundled") with another service for reimbursement purposes.

Carrier: A Medicare contractor responsible for physician and ASC medical policies, adjudication of claims and other administrative functions.

CC: Complications and Comorbidities. Patient conditions utilized as two of several factors in MS-DRG Groupers.

CCI: Correct Coding Initiative. A listing of CPT® Codes that are designated as comprehensive or component codes. If comprehensive and component codes are submitted on the same bill, only the comprehensive code will be paid unless a modifier is submitted. Medicare uses these as NCCI (National Correct Coding Initiative) edits.

CPT® Code: Current Procedural Terminology Code. These 5-digit numeric codes are the property of the American Medical Association and are used to describe physician services. Additionally, Medicare licenses these codes from the AMA and uses them to describe physician, hospital outpatient, ASC services, and other outpatient services.

DRG: Diagnosis Related Group. A numeric classification system used by Medicare and some commercial payers to reimburse for hospital inpatient services. The DRG is assigned by software that considers the ICD-9 procedure and diagnosis codes submitted on a claim.

DME: Durable Medical Equipment. Certified supplies, prosthetics, equipment, etc., provided to patients in other than a hospital inpatient setting.

DMERC: Durable Medical Equipment Regional Contractor. Medicare contractor that adjudicates claims for DME providers.

Facility / Non-Facility: For some physician procedures, the reimbursement is determined by the site of service. If the fee is designated as "Facility," the procedure is performed in a site of service other than a physician office. If the fee is designated as "Non-Facility," the procedure is performed in a physician office.

FI: Fiscal Intermediary. A Medicare contractor responsible for hospital inpatient and outpatient medical policies, adjudication of claims and other administrative functions.

HCPCS: Healthcare Common Procedure Coding System. The name of a coding system established by Medicare to describe services and supplies. The base (Level I) codes are CPT® Codes.

ICD-9: International Classification of Diseases. Numeric codes used by essentially all payers to describe diagnosis and procedures. The combination of procedure and diagnosis codes determines DRG assignment for inpatient reimbursement.

ICD-9 procedure 4-digit codes (e.g., 39.90 Insertion of non-drug-eluting peripheral vessel artery stent(s)) Abbrev: Px.

ICD-9 diagnosis 3, 4 or 5-digit codes (e.g., 586 Renal failure, unspecified) Abbrev: Dx.

Inpatient: The status used to describe a patient who has been admitted to the hospital. Usually involves multi-day stay.

IPPS: Inpatient Prospective Payment System. Medicare (CMS) per case (see "DRG" and "MS-DRG") methodology for hospital inpatient services.

LCD / LMRP: Local Coverage Determination / Local Medical Review Policy. The written policies produced by Medicare contractors applicable to geographic areas. A CMS national policy (see NCD) supersedes a LCD.

MCC: Major Complications and Comorbidities. Patient conditions utilized as two of several factors in MS-DRG Groupers. MCC are typically significant acute manifestations or advanced stages of chronic conditions that would result in higher resource utilization in the course of treatment.

MS-DRG: Medicare Severity Diagnosis Related Group. A numeric classification system effective October 1, 2007 used by Medicare to reimburse for hospital inpatient services. The MS-DRG is assigned by the combination of ICD-9 procedure codes, diagnosis codes and the presence or absence of MCC / CCs as derived from the medical record documentation. The MS-DRG system was designed to more accurately pay hospitals based on patient severity of illness.

Modifier: A 2-digit alphanumeric code that is appended to a CPT® Code for further specificity.

NCD: National Coverage Determination. The written policies from Medicare that have a national jurisdiction (supersede any LCD).

Observation: Hospital outpatient services to monitor and assess a patient for determination of hospital admission or discharge.

OPPS: Outpatient Prospective Payment System. Medicare (CMS) per group (see "APC") methodology for hospital outpatient services.

Outpatient: A patient admitted to a hospital to receive treatment but not admitted as an inpatient (see "Observation").

Packaged: Certain supplies / procedures provided by a facility as described by CPT® Codes / HCPCS Codes may be included ("Packaged") with another service for reimbursement purposes.

Prospective: A predetermined reimbursement rate, regardless of the cost of that service.

Pro / Tech: Professional / Technical. For some diagnostic tests, the physician reimbursement is established in two components. The "Professional" component is for the physician supervision, interpretation and other personal service. The "Technical" component is for the equipment, supplies, staff and other costs related to the test.

S&I: Supervision and Interpretation. This term is sometimes used to differentiate the imaging service (professional reading / interpretation) from other components of the procedure, such as introduction and placement of catheters.

Unadjusted Rate: The prospective reimbursement rate before it is adjusted for local factors such as the wage index, graduate medical education, outlier cases, disproportionate share and other factors. This is sometimes called the "national average" rate. All Medicare reimbursement will have local adjustment factors.

RESOURCES

Suggested Resources: Coding and reimbursement is complex, specific to case documentation and variable by geographic location. Always consult current physician, hospital and ASC resources.



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1. CMS-1504-FC, Addendum E
2. *SIR Interventional Radiology Coding User's Guide*, Society of Interventional Radiology, available at: <http://directory.sirweb.org/store>
3. *Current Procedural Terminology CPT®, 2011*, American Medical Association: <http://www.ama-assn.org>
4. *ICD-9-CM 2011*
5. *CSI Navigator For: Interventional Radiology / Procedures 2011 ed.*; Coding Strategies, Inc.: <http://www.codingstrategies.com>
6. Coding Terminology and Acronyms and additional resource: <http://goremedical.com/coding/>

*** DISCLAIMER:** References to particular applications and procedures listed in this coding overview do not represent the appropriateness or market availability of any Gore Medical Product. The information contained in this coding overview is provided for general informational purposes only and should NOT be relied on for submission purposes without first consulting your professional coding resources.

Physicians and hospitals are responsible for selecting and reporting the code(s) that most accurately describe the procedure(s) performed, the products used and the patient's condition. The basis for accurate coding is clear and complete documentation in the medical record.

Providers should follow coding guidelines from the patient's insurer, and should also review the complete coding authorities (e.g., CPT®, HCPCS, ICD-9-CM) used by the insurer.

The identification of a code in this Coding Overview should not be construed to guarantee coverage for a product or procedure, or payment in any particular amount.