Medicare HCPCS C codes for reporting devices on hospital outpatient claims

*2020 edition**

Overview

CMS (Medicare) requires the reporting of device C codes for certain outpatient procedures. A list of current device category codes can be found on the CMS website www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complet-list-DeviceCats-OPPS.pdf. The following tables list the Gore catalogue number prefixes 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, please submit them via the Revenue Cycle Coding Strategies / W. L. Gore & Associates website, gore.rccsclients.com.

ALL PRODUCTS DO NOT HAVE C CODES

Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, HCPCS Codes That Will Be Paid Only as Inpatient Procedures for CY 2020, of the Hospital Outpatient Prospective Payment System Final Rule.[A] The first table below lists examples of Gore products that would not usually be reported with C codes because they are commonly used in conjunction with Status C inpatient-only procedures. Certain ancillary products (e.g., delivery sheaths, balloons) that are designed to be used in association with inpatient devices, but could appropriately be used in an outpatient setting, are listed in the applicable HCPCS category. The remaining tables list examples of Gore products that could be reported with C codes when used in the hospital outpatient setting. None of these lists are all inclusive.

No C code required for Medicare APC Status Indicator C (inpatient-only) procedures

Examples of products typically used in inpatient-only procedures

Catalogue number prefix	Product description
SB, SBT	Gore Bifurcated Vascular Grafts
PLC, PXC, PLA, PLL, PXL	GORE® EXCLUDER® AAA Endoprosthesis
RLT	GORE® EXCLUDER® AAA Endoprosthesis featuring C3® Delivery System
CEB, HGB	GORE® EXCLUDER® Iliac Branch Endoprosthesis
TGM, TGMR	GORE® TAG® Conformable Thoracic Stent Graft with ACTIVE CONTROL System
TGU	Conformable GORE® TAG® Thoracic Endoprosthesis
1PCM	GORE® PRECLUDE® Pericardial Membrane

Staple line reinforcement

Category HCPCS: C1781	Long descriptor: Mesh (implantable)
Catalogue Number Prefix	**Product Description**
1BSG, 12BSG	GORE® SEAMGUARD® Staple Line Reinforcement

Cardiovascular patch

Category HCPCS: C1768	Long descriptor: Graft, vascular
Catalogue number / Prefix	**Product description**
1803003004	GORE-TEX® Cardiovascular Patch .4 mm
1803006004	GORE-TEX® Cardiovascular Patch .4 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
1905007508	GORE-TEX® Cardiovascular Patch .8 mm
1910015008	GORE-TEX® Cardiovascular Patch .8 mm
1800610004	GORE-TEX® Cardiovascular Patch .4 mm
1802009004	GORE-TEX® Cardiovascular Patch .4 mm
1802014004	GORE-TEX® Cardiovascular Patch .4 mm
1702515006	GORE-TEX® Cardiovascular Patch .6 mm
1CVX	GORE® ACUSEAL Cardiovascular Patch

A. Hospital Outpatient Prospective Payment- Notice of Final Rulemaking with Comment (NFRM). Centers for Medicare and Medicaid Services Web site. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC . Published November 12, 2019. Accessed January 6, 2020.

Example: Catalogue number 1CVX101 is prefix 1CVX

Hernia and wall defect repair products

Category HCPCS: C1781	Long descriptor: Mesh (implantable)
Catalogue number prefix	**Product description**
1DLMCP	GORE® DUALMESH® PLUS Biomaterial
1DLMCPH	GORE® DUALMESH® PLUS Biomaterial with Holes
1DLMC	GORE® DUALMESH® Biomaterial
1MYMP	GORE® MYCROMESH® PLUS Biomaterial
1MYM	GORE® MYCROMESH® Biomaterial
FS, HH	GORE® BIO-A® Tissue Reinforcement
HP	GORE® BIO-A® Hernia Plug
13“xxx...”; 14“xxx...” (ex. 1305010020)	GORE-TEX® Soft Tissue Patch
GKF	GORE® SYNECOR Intraperitoneal Biomaterial
GKW	GORE® SYNECOR Preperitoneal Biomaterial
GBF	GORE® ENFORM Intraperitoneal Biomaterial
GBW	GORE® ENFORM Preperitoneal Biomaterial

Interventional products

Category HCPCS: C1725	Long descriptor: Catheter, transluminal angioplasty, nonlaser (may include guidance, infusion / perfusion capability)
Catalogue number prefix	**Product description**
MOB	GORE® Molding & Occlusion Balloon
BCL	GORE® Tri-Lobe Balloon Catheter, large enhanced design
BCM	GORE® Tri-Lobe Balloon Catheter, small enhanced design
Q50	Q50® PLUS Stent Graft Balloon Catheter

Category HCPCS: C1817	Long descriptor: Septal defect implant system, intracardiac
Catalogue number prefix	**Product description**
ASD	GORE® CARDIOFORM ASD Occluder
GSX	GORE® CARDIOFORM Septal Occluder

Category HCPCS: C1874	Long descriptor: Stent coated / covered with delivery system
Catalogue number prefix	**Product description**
VBC, VBH, VBJ	GORE® VIABAHN® Endoprosthesis
BXA	GORE® VIABAHN® VBX Balloon Expandable Endoprosthesis
VH, VN	GORE® VIABIL® Biliary Endoprosthesis
VSWVH, VSWVN	GORE® VIABIL® Short Wire Biliary Endoprosthesis
PTB	GORE® VIATORR® TIPS Endoprosthesis, GORE® VIATORR® TIPS Endoprosthesis with Controlled Expansion
PHA	GORE® TIGRIS® Vascular Stent

Category HCPCS: C1884	Long descriptor: Embolization protection system
Catalogue number prefix	**Product description**
GEF	GORE® Embolic Filter

Introducer / sheath

Category HCPCS: C1894	Long descriptor: Introducer / sheath, other than guiding, other than intracardiac electrophysiological, nonlaser
Catalogue number prefix	**Product description**
DSF	GORE® DrySeal Flex Introducer Sheath
DSL	GORE® DrySeal Sheath with Hydrophilic Coating

Category HCPCS: C1887	Long descriptor: Catheter, guiding, may include infusion / perfusion capability
Catalogue number prefix	**Product description**
TSTH	GORE® TIPS Sheath
TSET	GORE TIPS Set
TNDL	GORE TIPS Needle

Example: Catalogue number DSF1233 is prefix DSF

***IMPORTANT:** This is an abbreviated list. All Gore Vascular Graft catalogue numbers are eligible for C1768. This list indicates the 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**
0650HYB	GORE® Hybrid Vascular Graft
ECH	GORE® ACUSEAL Vascular Graft
H	GORE® PROPATEN® Vascular Graft, standard-walled, stretch
H	GORE® PROPATEN® Vascular Graft, standard-walled, stretch, tapered
HAX	GORE® PROPATEN® Vascular Graft, standard-walled, axillobifemoral, removable ringed
HPT	GORE® PROPATEN® Vascular Graft configured for Pediatric Shunt
HR	GORE® PROPATEN® Vascular Graft, standard-walled, fixed ringed
HT	GORE® PROPATEN® Vascular Graft, thin-walled, stretch
HT	GORE® PROPATEN® Vascular Graft, thin-walled, removable ringed, stretch
IR	GORE® INTERING® Vascular Graft, standard-walled
IRH	GORE® PROPATEN® Vascular Graft, standard-walled, integrated rings
IRH	GORE® PROPATEN® Vascular Graft, standard-walled, integrated rings, tapered
IRS	GORE® INTERING® Vascular Graft, standard-walled, stretch
IRS	GORE® INTERING® Vascular Graft, standard-walled, stretch, tapered
IRST	GORE® INTERING® Vascular Graft, thin-walled, stretch
IRTH	GORE® PROPATEN® Vascular Graft, thin-walled, integrated rings
R	GORE-TEX® Vascular Graft, standard-walled, ringed
RD	GORE-TEX® Vascular Graft, standard-walled, ringed, dialysis
RR	GORE-TEX® Vascular Graft, standard-walled, removable ringed
RR	GORE-TEX® Vascular Graft, standard-walled, removable ringed, tapered
RRT	GORE-TEX® Vascular Graft, thin-walled, removable ringed
RT	GORE-TEX® Vascular Graft, thin-walled, ringed
S	GORE-TEX® Stretch Vascular Graft, standard-walled
S	GORE-TEX® Stretch Vascular Graft, standard-walled, tapered
S, SA	GORE-TEX® Stretch Vascular Graft, standard-walled, large diameter
SAX	GORE-TEX® Stretch Vascular Graft, standard-walled, axillobifemoral, removable ringed
SB	GORE-TEX® Stretch Vascular Graft, standard-walled, bifurcated
SBT	GORE-TEX® Stretch Vascular Graft, thin-walled, bifurcated
SR	GORE-TEX® Stretch Vascular Graft, standard-walled, ringed
SRD	GORE-TEX® Stretch Vascular Graft, standard-walled, ringed, dialysis
SRT	GORE-TEX® Stretch Vascular Graft, thin-walled, ringed
SRRT	GORE-TEX® Stretch Vascular Graft, thin-walled, removable ringed
ST	GORE-TEX® Stretch Vascular Graft, thin-walled and GORE-TEX® Stretch Vascular Graft, pediatric shunt
V	GORE-TEX® Vascular Graft, standard-walled
V	GORE-TEX® Vascular Graft, standard-walled, tapered
VT	GORE-TEX® Vascular Graft, thin-walled and GORE-TEX® Vascular Graft, pediatric shunt
VT	GORE-TEX® Vascular Graft, thin-walled, tapered

Example: Catalogue number SR08050070L is prefix SR

Terminology and acronyms

A / B Medicare Administrative Contractor (A / B MAC): A Medicare contractor responsible for administration and adjudication of claims for hospital inpatient, hospital outpatient, physicians and ASC treatment settings.

Advance Beneficiary Notice (ABN): 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.

Ambulatory Payment Classification (APC): 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 percent and all others at 50 percent. For all APCs with Status Indicator "S" each APC will be paid at 100 percent without discounting.

Ambulatory Surgery Center (ASC): 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® / HCPCS codes may be included ("bundled") with another service for reimbursement purposes.

Comprehensive Ambulatory Payment Classification (C-APC): These APCs provide all-inclusive payments for certain procedures. This policy packages payment for all items and services typically packaged under the OPPS and also packages payment for other items and services that are not typically packaged under the OPPS. The single payment for a comprehensive APC excludes services that cannot be covered by Outpatient Department (OPD) services or cannot by statute be paid under the OPPS.

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

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

Correct Coding Initiative (CCI): 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.

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare program. CMS also works with the states to run the Medicaid program.

Current Procedural Terminology Code (CPT® 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.

Diagnosis-Related Group (DRG): 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-10 procedure and diagnosis codes submitted on a claim.

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

Durable Medical Equipment Regional Contractor (DMERC): 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.

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

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

International Classification of Diseases (ICD-10): Alphanumeric clinical coding system for diagnoses and procedures. The combination of procedure and diagnosis codes determines DRG assignment for inpatient reimbursement.

ICD-10 procedure	7 character alphanumeric codes (e.g., 04V03DZ Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach) Abbrev: Px.
ICD-10 diagnosis	3–7 alphanumeric codes (e.g., I71.4 Abdominal aortic aneurysm, without rupture) Abbrev: Dx.

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

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

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

Major Complications and Comorbidities (MCC): 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.

Major Diagnostic Category (MDC): Individual MS-DRGs are grouped into mutually exclusive groups based on principal diagnosis. Each group (MDC) generally corresponds to a single organ system and is further organized into a medical or surgical section. A case is assigned to a surgical section MDC based on operating room procedure performed.

Medicare Severity Diagnosis-Related Group (MS-DRG) A numeric classification system used by Medicare to reimburse for hospital inpatient services. The MS-DRG is assigned by the combination of ICD-10 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.

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

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

Outpatient Prospective Payment System (OPPS): Medicare 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® / HCPCS codes may be included ("packaged") with another service for reimbursement purposes.

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

Professional / Technical (Pro / Tech): 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.

Supervision and Interpretation (S & I): 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.

1. Hospital Outpatient Prospective Payment- Notice of Final Rulemaking with Comment (NFRM). Centers for Medicare and Medicaid Services Web site. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1717-FC . Published November 12, 2019. Accessed January 6, 2020.

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* **Disclaimer:** The payment amounts listed in this guide are national averages. Actual payment will vary based on several factors including the site of the service, geographic location, patient population mix and hospital teaching status. References to particular applications and procedures listed in this overview do not represent the appropriateness or market availability of any Gore medical product. The information contained in this overview is provided for general information purposes only and should NOT be relied on for submission purposes. Consult your professional resources and the patient's insurer for situation-specific information.

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, precisely describing the procedures performed and products used.

Providers should follow coding guidelines from the patient's insurer and should also review the complete coding authorities (e.g., CPT®, HCPCS, ICD-10-CM, ICD-10-PCS) used by the insurer.

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

Products listed may not be available in all markets.

Consult Instructions for Use