Transcatheter Closure of Atrial Septal Defects
Coverage, Coding and Reimbursement Overview — Physician/Hospital

2016 Edition — All Reimbursement Amounts are Listed at National Medicare Rates and Do Not Include the 2% Sequestration Reduction

**PHYSICIAN OVERVIEW**

**Coverage**
- Medicare: A/B MAC/Carrier Local Coverage Determination
- Medicaid: State Policies
- Commercial Insurance: Plan Design, Medical Policies, Patient Eligibility

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT Code</th>
<th>Professional or Facility</th>
<th>Technical or Non-Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant</td>
<td>93580</td>
<td>$1,017</td>
<td>—</td>
</tr>
</tbody>
</table>

**Potential Ancillary Services**
- Transthoracic echocardiography for congenital cardiac anomalies; complete
- Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study
- Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
- Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only
- Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only
- Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging S&I

**HOSPITAL (FACILITY) OVERVIEW**

**Coverage**
- Medicare: A/B MAC/Fiscal Intermediary Local Coverage Determination
- Medicaid: State Policies
- Commercial Insurance: Plan Design, Medical Policies, Patient Eligibility

**Procedure**
- Septal defect implant system, intracardiac
- ICD-10-PCS: Supplement; Atrial Septum; Percutaneous or Percutaneous Endoscopic; Synthetic Substitute
- Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

**Imaging**
- Transthoracic echocardiography for congenital cardiac anomalies; complete
- Transthoracic echocardiography with contrast for congenital cardiac anomalies; complete
- Transthoracic echocardiography with contrast for congenital cardiac anomalies; follow-up or limited study
- Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
- Transesophageal echocardiography (TEE) with contrast for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
- Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only
- Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only
- Intracardiac echocardiography during therapeutic / diagnostic intervention, including imaging S&I

B. Abbreviated CPT® code descriptions. See CPT® codebook for complete descriptions.
C. For imaging services (excluding screening and diagnostic mammograms), the DRA of 2005 caps the physician technical component rate at the payment level established for the OPPS fee schedule.
D. Certain imaging and diagnostic cardiovascular services are subject to Multiple Procedure Payment Reduction rules—refer to CMS-1633-FC for affected services.
E. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.
F. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement.
G. Rates per CMS-1633-FC.
H. Status Indicators: C-Inpatient Procedures; J-Hospital Part B Services Paid Through a Comprehensive APC; N-Items and Services Packaged into APC Rates; Q1-STV-Packaged Codes; Q2-T-Packaged Codes.
J. Codes That May Be Paid Through a Composite APC: S-Procedure or Service. Not Discounted When Multiple; T-Procedure or Service. Multiple Procedure Reduction Applies.
K. Rates per CMS-1633-FC.
L. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement.
M. Procedures that require the implantation of a device assigned to a device-intensive APC (Table 42) require a device HCPCS code and NCCI edits apply per CMS-1633-FC.