

Introduction

This coding guide is intended to provide reference material related to general guidelines for the reimbursement of imaging for cardiac procedures when used consistently with the products labeling. This guide includes information regarding coverage, coding, and payment.

The Center for Medicare and Medicaid Services (CMS) created a new code, C9793, on January 1, 2024. The code is intended to be utilized in the outpatient setting and involves the use of computed tomography angiography (CTA) in planning for a cardiac procedure. On April 1, 2025, CMS modified the code descriptor to include the use of CMR in generating 3D models for pre-procedural planning in a cardiac procedure.

As the code is approved for outpatient services at the time the imaging procedure is completed, and the imaging may be conducted by cardiac imaging specialists or radiologists, recognizing revenue among different departments will need to be determined locally. It is appropriate for providers to invoice C9793 to third party payors when either CTA or CMR are utilized for 3D planning of a cardiac procedure.

Coding and Reimbursement

HCPCS	Long Descriptor	Status Indicator*	APC	APC Description	2026 HOPPS Allowed Amount
C9793	3D predictive model generation for preplanning of a cardiac procedure, using data from cardiac computed tomographic angiography and/or magnetic resonance imaging with report	S	5724	Level 4 Diagnostic Tests and Related Services	\$877.34

*Status Indicator S = Procedure or service not subject to multiple procedure discounting

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