CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 658 **Date: AUGUST 26, 2005**

CHANGE REQUEST 4017

SUBJECT: Billing for Devices Under the Hospital Outpatient Prospective Payment System (OPPS)

I. SUMMARY OF CHANGES: This transmittal revises language found in Chapter 4, §61 entitled "Billing for Devices Under the OPPS" to delete incorrect and obsolete tables of device codes. This transmittal advises contractors to refer the reader to the CMS Web sites with correct tables of Healthcare Common Procedure Coding System (HCPCS) codes for devices and OCE edits that apply when procedures that require devices are billed under the OPPS.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2005
IMPLEMENTATION DATE: October 3, 2005

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/Table of Contents
R	4/61/Billing for Devices Under the OPPS
R	4/61.1/Requirements that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures
R	4/61.2/Edits for Claims on Which Specified Procedures are to be Reported With Device Codes

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 658	Date: August 26, 2005	Change Request 4017

SUBJECT: Billing for Devices Under the Hospital Outpatient Prospective Payment System (OPPS)

I. GENERAL INFORMATION

A. Background: This transmittal revises language found in Chapter 4, §61 entitled "Billing for Devices Under the OPPS" to delete incorrect and obsolete tables of device codes. This transmittal advises contractors to refer the reader to the CMS Web sites with correct tables of Healthcare Common Procedure Coding System (HCPCS) codes for devices and OCE edits that apply when procedures that require devices are billed under the OPPS.

Under OPPS, we package payment for an implantable device into the Ambulatory Payment Classification (APC) Groups payment for the procedure performed to insert the device. Because the pass-through status of so many device categories expired at the end of CY 2002, we discontinued the C-codes that had been established to report pass-through devices in CY 2003. However, we have found that the claims we use to set payment rates for APC that require devices ("device-dependent" APCs) frequently have packaged costs that are much lower than the cost of the devices associated with the procedures. We attribute this anomalous cost data in part to variable hospital billing practices. Therefore, to improve the specificity of claims data, we reestablished device C-codes and encouraged hospitals, on a voluntary basis, to report device codes and charges on claims for services associated with devices in CY 2004. For CY 2005, we required hospitals to report device C-codes for devices used in procedures on their claims if appropriate device codes exist. Our goal is to capture the costs of all devices utilized in procedures in the hospital claims data used to develop APC payment rates. Specifically with respect to device-dependent APCs paid under the OPPS, our objective is to base payment on single bill claims data, without adjustment for erratic data.

On December 17, 2004, we issued Change Request 3606, Transmittal 403, which announced that, effective April 1, 2005, we would edit for the presence of specified device codes when hospitals billed certain procedure codes under the OPPS. The tables of HCPCS codes for devices and of procedure code to device code edits contained in that transmittal are incorrect and obsolete. Change Request 4017 refers to the CMS Web site locations at which the correct and timely information can be found. The Web site information will be updated as needed and any changes would be effective on the calendar quarter.

B. Policy: Effective October 1, 2005, hospitals paid under the OPPS (bill types 12X and 13X) and contractors that process claims for services under OPPS must look to the CMS Web site for the specific HCPCS codes for devices that must be reported on claims for procedures that use the devices, and must also look to the CMS Web site for the OCE procedure code to device code edits that apply.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4017.1	Contractors shall use the CMS Web site at www.cms.hhs.gov/medicare/HCPCS to identify codes for devices that must be billed by hospitals for services paid under OPPS.	X								
4017.2	Contractors shall use the CMS Web site at www.cms.hhs.gov/providers/hopps to identify the device codes that must be reported with specific procedure codes for a claim to be accepted by OCE.	X								OCE
4017.3	Contractors shall refer inquirers to the CMS Web site at www.cms.hhs.gov/medicare/HCPCS to identify codes for devices that must be billed by hospitals for services paid under OPPS.	X								
4017.4	Contractors shall refer inquirers to the CMS Web site at www.cms.hhs.gov/providers/hopps to identify the device codes that must be reported with specific procedure codes for a claim to be accepted by OCE.	X								OCE
4017.5	Contractors shall send questions about the device code requirements on the CMS Web site to outpatientpps@CMS.hhs.gov.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4017.6	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: **October 1, 2005** **Implementation Date: October 3, 2005** **Pre-Implementation Contact(s):** Marina Kushnirova marina.kushnirova@cms.hhs.gov Anita Heygster anita.heygster@cms.hhs.gov **Post-Implementation Contact(s):** Regional office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2005 operating budgets.**

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Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev.658, 08-26-05)

61-Billing for Devices Under the OPPS

(Rev.658, Issued: 08-26-05, Effective: 10-01-05, Implementation: 10-03-05)

61.1 Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures

(Rev.658, Issued: 08-26-05, Effective: 10-01-05, Implementation: 10-03-05)

Effective January 1, 2005, hospitals paid under the OPPS (bill types 12X and 13X) that report procedure codes that require the use of devices must also report the applicable HCPCS codes and charges for all devices that are used to perform the procedures where such codes exist. This is necessary so that the OPPS payment for these procedures will be correct in future years in which the claims are used to create the APC payment amounts. Current HCPCS codes for devices are found at http://www.cms.hhs.gov/medicare/HCPCS.

61.2 Edits for Claims on Which Specified Procedures are to be Reported With Device Codes

(Rev.658, Issued: 08-26-05, Effective: 10-01-05, Implementation: 10-03-05)

The OCE will return to the provider any claim that reports a HCPCS code for a procedure listed in the table of device edits that does not also report at least one device HCPCS code required for that procedure as listed on the CMS Web site at http://www.cms.hhs.gov/providers/hopps/. The table shows the effective date for each edit. If the claim is returned to the provider for failure to pass the edits, the hospital will need to modify the claim by either correcting the procedure code or ensuring that one of the required device codes is on the claim before resubmission. While all devices that have device HCPCS codes, and that were used in a given procedure should be reported on the claim, where more than one device code is listed for a given procedure code, only one of the possible device codes is required to be on the claim for payment to be made, unless otherwise specified.

Device edits do not apply to the specified procedure code if the provider reports one of the following modifiers with the procedure code:

52 - Reduced Services;

73 -- Discontinued outpatient procedure prior to anesthesia administration; and

74 -- Discontinued outpatient procedure after anesthesia administration.

Where a procedure that normally requires a device is interrupted, either before or after the administration of anesthesia if anesthesia is required or at any point if anesthesia is not required, and the device is not used, hospitals should report modifier 52, 73 or 74 as applicable. The device edits are not applied in these cases.