



Related MLN Matters Article #: SE0732

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Adjustment to Payment Under Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for Partial Device Credit

Key Words

SE0732, CR5668, OPPS, ASC, R1383CP, Payment, Partial, Device, Credit

Provider Types Affected

Providers submitting claims to Medicare Carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries, which are paid under the OPPS or the ASC payment system

Key Points

- In general, the Centers for Medicare & Medicaid Services (CMS) includes the full payment for devices with the payment for the service in which the device is used by using only outpatient hospital claims that contain the full cost of medical devices in setting the Medicare payment rates.
- In some cases, the cost of the device is a very large proportion of the cost of the procedure on which the Ambulatory Payment Classification (APC) payment for the procedure is based.
- Therefore, when the provider receives partial credit for the device and does not incur the full cost of the procedure, it is necessary to adjust the payment so that the payment reflects the reduced cost of the device. This is necessary to:
 - Provide an appropriate payment for the service, and
 - Ensure that the Medicare beneficiary's co-payment liability is reduced when appropriate.
- CMS determined that partial credits occur more commonly than do full credits or no cost devices.
- In addition, CMS has learned that typical industry practice for some types of devices is to:
 - Provide a 50 percent credit in cases of device failure (including battery depletion) under warranty if a device failed before 3 years of use, and

- Prorate the credit over time (between 3 and 5 years) after the initial device implantation, as the useful life of the device declines.
- In these cases, neither the hospital nor ASC is incurring the full cost of the device, although the Medicare payment is calculated based on the full cost of the device.
- Effective for services furnished on or after January 1, 2007, CMS implemented a policy to adjust the OPPOS payment for procedures assigned to selected APCs when any of the specified devices was implanted in a beneficiary (and remained in the patient at least temporarily) and was furnished either without cost or with full credit for the cost of the device being replaced.
- Hospitals report the occurrence of a no cost or full credit device to CMS by reporting the –FB modifier on the line with the procedure code in which the no cost or full credit device is used when the device is on the list of specified devices to which this policy applies. The list of affected devices and APCs is located at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.
- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Section 626) requires implementation of a revised ASC payment system no later than January 1, 2008.
- The revised payment system to be implemented January 1, 2008, is based on the relative payment weights established under the OPPOS and many of the payment policies of the OPPOS, including the full device credit policy.
- **Effective January 1, 2008, CMS is also implementing a partial device credit policy under both the OPPOS and the ASC payment system.**
- Hospitals and ASCs report the occurrence of a partial credit device to CMS by reporting the –FC modifier on the line with the procedure code in which the partial credit device is used when the device is on the list of specified devices to which this policy applies.
- The devices, APCs, and covered ASC surgical procedures to which the partial device credit policy applies are the same as the devices, APCs, and covered ASC surgical procedures to which the full device credit policy applies (–FB modifier).
- For services furnished on or after January 1, 2008, hospitals and ASCs are required to report modifier –FC, with the procedure code for all cases in which:
 - The device being implanted is on the list of creditable devices;
 - The procedure code in which the device is used is assigned to an APC that is on the list of APCs to which the policy applies in the case of hospitals, or on the list of procedures to which the policy applies in the case of ASCs; and
 - The hospital or ASC received a credit of 50 percent or more of the estimated cost of the new replacement device.
- The list of devices, APCs, and ASC procedures to which this policy applies is available at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS website.
- The reduction to the APC payment amount when the hospital reports a partial credit for the new replacement device is available on that website as well. An ASC will receive the same amount of payment reduction (in dollars) as a hospital when it reports receiving a partial device credit for a particular procedure.

- Providers should remember that both hospitals and ASCs are required to report the –FC modifier with the code for the device implantation procedure, not with the code for the device.
- Failure to include the proper modifiers on claims as appropriate may result in payment to which the provider is not entitled. If hospitals report the modifier with the device code instead of the procedure code, the claim will be returned.
- Because hospitals may not know the amount of credit the manufacturer will provide for the replacement device when the replacement procedure takes place, hospitals will have the option of either:
 - Submitting the claim for the device replacement procedure to their Medicare contractor immediately without the -FC modifier and then submitting a claim adjustment with the -FC modifier at a later date once a credit determination is made; or
 - Holding the claim for the device replacement procedure until a determination is made by the manufacturer on the partial credit amount, and submitting the claim with the -FC modifier appended to the implantation procedure code if the partial credit is 50 percent or more of the cost of the replacement device.
- ASCs have the same two billing options as outlined above for hospitals, but if an ASC chooses Option 1 and bills for a replacement device procedure prior to receiving a manufacturer's credit determination, it must subsequently contact the Medicare contractor regarding a claims adjustment if a credit of 50 percent or more is received.
- When hospitals or ASCs use Option 1, they should be mindful that the initial Medicare payment for the procedure involving the replacement device is conditional and subject to adjustment.
- Hypothetical examples that illustrate the revised policy are shown in the tables in the Background Section of MLN Matters article SE0732, beginning on page 5.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0732.pdf> on the CMS website.

A special edition MLN Matters article outlining the new ASC payment system is available at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS website.

To view the official instruction (CR5668) on which article SE0732 is based, providers may visit

<http://www.cms.hhs.gov/Transmittals/downloads/R1383CP.pdf> on the CMS website.

Providers may also want to review:

- CR5263 (Transmittal 1103, November 3, 2006) located at <http://www.cms.hhs.gov/Transmittals/downloads/R1103CP.pdf>,
- MLN Matters article MM5263 ("Reporting and Payment of No-Cost Devices Furnished by Outpatient Prospective Payment System (OPPS) Hospitals") located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5263.pdf>, and
- The *Medicare Claims Processing Manual* (Pub.100-4, Chapter 4, Section 61.3 at <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>) on the CMS website.

If providers have any questions, they may contact their Medicare Carrier, FI, or A/B MAC at their toll-free number, which may be found on the CMS website at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.