



Related MLN Matters Article #: MM5263

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Reporting and Payment of No-Cost and Reduced-Cost Devices Furnished by Outpatient Prospective Payment System (OPPS) Hospitals

Key Words

MM5263, CR5263, R1103CP, PPS, Hospital, No-Cost, Device

Provider Types Affected

Providers and suppliers submitting claims to Medicare Fiscal Intermediaries (FIs) for devices used in the process of providing services to Medicare beneficiaries

Key Points

- The effective date of the instruction is January 1, 2007.
- The implementation date is January 2, 2007.
- Change Request (CR) 5263 expands the definition of modifier – '*FB*' and further specifies how no-cost devices and reduced cost devices are to be reported and paid for by hospitals paid under the Outpatient Prospective Payment System (OPPS).
- Medicare packages payment for devices into the payment for the service in which the device is used. In some cases, the cost of the device is a very large proportion of the cost for the procedure on which the Ambulatory Payment Classification (APC) payment for the procedure is based.
- Section 1862(a) (2) of the Social Security Act excludes payment for items or services for which neither the beneficiary nor any party on the beneficiary's behalf are liable. Therefore, it is necessary to adjust the payment for the APC so that it no longer includes payment for a device that is being furnished without cost to the beneficiary.
- Medicare requires that hospitals paid under OPPS must report the Healthcare Common Procedure Coding System (HCPCS) code for devices they use in performing a service including those implanted in a patient (temporarily or permanently); and the Outpatient Code Editor (OCE) returns claims to the provider for selected HCPCS procedures if an approved HCPCS code for the device is not included on the claim.

- Medicare claims processing system used by FIs requires that there be a charge for each HCPCS code reported on the claim; and an OPSS hospital may not refrain from billing for a device furnished under warranty without cost to the provider or beneficiary.
- The Centers for Medicare & Medicaid Services (CMS) authorized hospitals (in CR3915) to report a token charge of less than \$1.01 for the device in these cases so that the claim could be processed. See the MLN Matters article associated with CR 3915 (Transmittal 599, June 30, 2005) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3915.pdf>.
- CMS subsequently announced in CR4250 the creation of modifier 'FB', with the following definition:
 - ***Item Provided Without Cost to Provider, Supplier or Practitioner (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)***. See the MLN Matters article associated with CR4250 (Transmittal 804, January 3, 2006) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4250.pdf>.
 - CR5263 expands the definition of modifier 'FB' to include **credits received for a replacement device** by a hospital from a manufacturer or other entity effective January 1, 2007.
 - CR5263 further revises the *Medicare Claims Processing Manual* (Chapter 4) which instructs OPSS hospitals to:
 - Report modifier – 'FB' on the same line as the procedure code (not the device code) for a service that requires a device:
 - For which neither the hospital, nor the beneficiary, is liable to the manufacturer; or
 - When the manufacturer gives credit for a device being replaced with a more costly device.
 - Append modifier – 'FB' to the procedure code (not the device code) that reports the services provided to replace the device when the hospital:
 - Replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS web site at <http://www.cms.hhs.gov/HospitalOutpatientPPS/>); and
 - Receives the device without cost from a manufacturer. The hospital must report a token charge for the device (less than \$1.01) in the covered charges field; or
 - Receives a credit in the amount that the device being replaced would otherwise cost. The hospital must charge the difference between its usual charge for the device being implanted and its usual charge for the device for which it received credit. This charge should be billed in the covered charges field.
- Payment for the replacement procedure is reduced by the offset amount applicable to the APC for which the service was furnished. These offset amounts are displayed at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS web site.

- The table on pages 3 and 4 of MLN Matters article MM5263 includes hypothetical claim examples and aims to reflect the pricing concepts, effective January 1, 2007. The rates in the examples do not represent actual payment rates because they are rounded to simplify the example claims scenarios.

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5263.pdf> on the CMS web site.

The official instruction issued to the intermediary regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1103CP.pdf> on the CMS web site.

If providers have any questions, they may contact their intermediary at their toll-free number, which may be found on the CMS web site at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>.