



Payment for Implanted Prosthetic Devices for Medicare Part B Inpatients - JA6050

Note: MLN Matters article MM6050 was revised to reflect revisions made to Change Request (CR) 6050, which was revised to reflect that the new C-Code is Healthcare Common Procedure Coding System (HCPCS) code C9899. In addition, the CR release date, transmittal number, and Web address for accessing CR6050 were revised.

Related CR Release Date: November 3, 2008

Date Job Aid Revised: November 10, 2008

Effective Date: January 1, 2009 **Revised**

Implementation Date: January 5, 2009

Key Words MM6050, CR6050, R1628CP, Implanted, Prosthetic, Devices

Contractors Affected

- Fiscal Intermediaries (FIs)
- Part A/B Medicare Administrative Contractors

Provider Types Affected Providers submitting claims to FIs and/or A/B MACs for implanted prosthetic devices provided to Medicare beneficiaries under Part B



- CR6050 clarifies payment for implanted prosthetic devices for Medicare Part B inpatients.
- It provides instructions regarding how contractors are to establish the payment to be made under the Outpatient Prospective Payment System (OPPS) for implanted prosthetic devices that are furnished to Medicare beneficiaries who are hospital inpatients without Part A coverage of services, but with Part B coverage, on the date that the device is implanted.

- The *Medicare Claims Processing Manual*, Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 240 (Inpatient Part B Hospital Services) is being revised to specify that:

Provider Needs to Know...

- Providers must submit services for implanted prosthetic devices on a 12X type of bill, reporting a new **HCPCS code (C9899)** that will be effective for services furnished on and after January 1, 2009, when they furnish an implanted prosthetic device to a Medicare beneficiary:
 - Who is a hospital inpatient, but
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- Who does not have Part A coverage of inpatient services on the date that the implanted prosthetic device is furnished.

Note: By reporting the new C9899 code, the hospital is reporting that all of the criteria for payment under Part B are met as specified in the Chapter 6, Section 10 of the *Medicare Benefits Policy Manual*.

- The revised manual also specifies that Medicare contractors will:
 - Determine if the device meets the definition for an implanted prosthetic device, and if so,
 - Establish the payment to be made for the device.

Determining Coverage of the Device

- Medicare contractors will first determine that the item furnished meets the Medicare criteria for coverage as an implantable prosthetic device as specified in Chapter 6, Section 10, of the *Medicare Benefits Policy Manual*.
- If the **item does not meet the criteria for coverage** as an implantable prosthetic device, the Medicare contractor will deny payment on the basis that the item is outside the scope of the benefits for which there is coverage for Part B inpatients.
- The beneficiary is liable for the charges for the noncovered item when the item does not meet the criteria for coverage as an implanted prosthetic device as specified in Chapter 6, Section 10 of the *Medicare Benefits Policy Manual*.

Determining Payment

- Once the Medicare contractor determines that **the device is covered**, it will then determine the appropriate payment amount for the device.
- The contractor will begin this process by determining if the device has pass-through status under the OPPS. If so, the contractor will establish the payment amount for the device at the product of the charge for the device and the hospital specific cost to charge ratio.
- Where the device does not have pass-through status under the OPPS, the contractor will set the payment amount for the device at the lesser of the amount for the device, in the Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) fee schedule, where there is such an amount or the actual charge for the device.
- Where there is no amount for the device in the DMEPOS fee schedule, the contractor will establish a payment amount that is specific to the particular implanted prosthetic device for the applicable calendar year. Payment would be made at the lesser of the contractor established payment rate for the specific device or the actual charge for the device.
- In setting a Medicare contractor established payment rate for the specific device, the contractor takes into account the cost information available at the time the payment rate is established.
- This information may include, but is not limited to, the amount of device cost that would be removed from an applicable Ambulatory Patient Classification (APC) payment for

implantation of the device if the provider received a device without cost or a full credit for the cost of the device.

- To see the amount of reduction to the APC payment that would apply in these cases, providers should:
 - Go to http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage on the CMS website;
 - Open the file "Procedure to Device Edits" to determine the HCPCS code that best describes the procedure in which the device would be used.
 - Then identify the APC to which that procedure code maps from the most recent Addenda B on the OPPS webpage and open the file "APC Adjustments in Cases of Full Credit/No Cost or Partial Credit for Replaced Devices." Select the "Full offset reduction amount" that pertains to the APC that is most applicable to the device described by the new C9899 code.
- It would be reasonable to set this amount as the payment for a device furnished to a Part B inpatient.
 - For example, if the new C9899 code is reporting insertion of a single chamber pacemaker (C1786 or equivalent narrative description on the claim in "remarks"), the file of "procedure to device edits" shows that a single chamber pacemaker is the dominant device for APC 0090 (APC 0089 is for insertion of both pacemaker and electrodes and therefore, would not apply if electrodes are not also billed).
 - The table of offset reduction amounts for calendar year 2008 shows that the estimated cost of a single chamber pacemaker for APC 0090 is \$4881.77. It would therefore be reasonable for the FI or MAC to set the payment rate for a single chamber pacemaker furnished to a Part B inpatient to \$4881.77. In this case, the coinsurance would be \$936.75 (20 percent of \$4881.77, which is less than the inpatient deductible).
- The beneficiary coinsurance is 20 percent of the payment amount for the device (i.e., the pass-through payment amount, the DMEPOS fee schedule amount or the contractor established amount, or the actual charge where applicable), not to exceed the Medicare inpatient deductible that is applicable to the year in which the implanted prosthetic device is furnished.

Denial Message Codes

- Medicare contractors will deny payment for an item reported with the new C9899 code if they determine that it does not meet the definition of an implanted prosthetic device that is implanted in the body at least temporarily.
 - On such denials, the remittance advice remark code will show:
 - N180 ("This item or service does not meet the criteria for the category under which it was billed.) with a group code of PR ("Patient Responsibility") and
 - Claim adjustment reason code of 96 ("Non-covered charges").
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- Medicare contractors will also deny payment if they or Medicare systems determine that the beneficiary was in a covered Part A stay on the date of service of the item reported with the new C9899 code.
- Such denials will contain:
 - A remittance advice remark code of M2 ("Not paid separately when the patient is an inpatient"),
 - A group code of CO ("Contract Obligation"), and
 - A claim adjustment reason code of 96 ("Non-covered charges").

Background

- The Centers for Medicare & Medicaid Services (CMS) can designate medical and other health services (that are payable under the Medicare OPPS) for beneficiaries who are hospital inpatients with Medicare Part B benefits, but who do not have Part A benefits. See the Social Security Act (Section 1833(t)(2)(A)) at http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet.
- The *Medicare Benefits Policy Manual* (Chapter 2, Section 10) includes implanted prosthetic devices in the list of designated services for which payment may be made under the OPPS for Medicare beneficiaries who:
 - Are inpatients of a hospital but who are not covered under Medicare Part A at the time of implantation, but
 - Have Part B coverage on the day that they receive an implanted prosthetic device.
- The processing of claims for these services is discussed in the *Medicare Claims Processing Manual* (Chapter 4, Section 240).
- Payment for these items is packaged into the OPPS payment for the procedure in which they are implanted.

Operational
Impact

N/A

Reference
Materials

- The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6050.pdf> on the CMS website.
- The official instruction (CR6050) issued regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1628CP.pdf> on the CMS website.