



Related MLN Matters Article #: MM4017

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Related CR #: 4017

## *Billing for Devices Under the Hospital Outpatient Prospective Payment System (OPPS)*

### Key Words

MM4017, CR4017, R658CP, billing, device, hospital, outpatient, prospective, payment

### Provider Types Affected

Providers billing services to Medicare fiscal intermediaries (FIs) that are paid under the OPPS

### Key Points

- The effective date of the instruction is October 1, 2005.
- The implementation date is October 3, 2005.
- Change Request (CR) 4017 revises language found in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 4, Section 61, titled "Billing for Devices under the OPPS."
- The changes delete incorrect and obsolete tables of device codes and Outpatient Code Editor (OCE) edits and refer the reader to the Centers for Medicare & Medicaid Services (CMS) websites with correct tables of Healthcare Common Procedure Coding System (HCPCS) codes for devices and Outpatient Code Editor (OCE) edits that apply when procedures that require devices are billed under the OPPS.
- See <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/> on the CMS website to identify codes for devices that must be billed by hospitals for services paid under OPPS.
- Use the CMS web page at [http://www.cms.hhs.gov/HospitalOutpatientPPS/02\\_device\\_procedure.asp#TopofPage](http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopofPage) identify the device codes that must be reported *with* specific procedure codes for a claim to be accepted by OCE.
- Send questions about the device code requirements on the CMS website to [outpatientpps@CMS.hhs.gov](mailto:outpatientpps@CMS.hhs.gov).
- While all devices that have device HCPCS codes (and that were used in a given procedure) should be reported on the claim, if more than one device code is listed (for a given procedure code), then 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;
  - 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, **then**
  - Hospitals should report modifier 52, 73, or 74 (listed in the previous table) as applicable.
  - The device edits are not applied in these cases.
- Effective **October 1, 2005**, hospitals paid under the OPSS (bill types 12X and 13X) must:
  - Use the specific HCPCS codes for devices as shown on the CMS website on claims for procedures that use the devices; and
  - Look to the CMS website for the procedure code to device code edits that apply.

## Important Links

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4017.pdf>

For complete details, affected providers should see the official instruction issued to their FI regarding this change. That instruction may be viewed by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R658CP.pdf> on the CMS website