Frequently Asked Questions on Hospital OPPS Billing for Replacement Devices

Q. How should hospital outpatient departments bill when they receive full credit for an implantable device being replaced with a device of similar cost?

A. When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS website at http://www.cms.hhs.gov/HospitalOutpatientPPS/); and 2) receives the device without cost from a manufacturer, the hospital must append modifier –FB to the procedure code (not the device code) that reports the service provided to replace the device. The hospital must report a token charge for the device (less than $1.01) in the covered charges field.

This includes circumstances in which the cost of the replacement device is less than the cost of the device being replaced, such that the hospital incurs no net cost for the device being inserted. For example, if a device that originally cost $20,000 fails and is replaced by a device that costs $16,000 and for which the manufacturer gives a credit of $16,000, there is no cost to the hospital for the device being inserted and the hospital would report the –FB modifier.

Q. How should hospital outpatient departments bill when they receive full credit for an implantable device being replaced by a more costly device (i.e., a device upgrade)?

A. When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS website at: http://www.cms.hhs.gov/HospitalOutpatientPPS/); 2) receives a credit in the amount that the device being replaced would otherwise cost, and 3) implants a more costly device so that the hospital incurs a net cost for the device being inserted, the hospital must append modifier -FB to the procedure code (not on the device code) that reports the service provided to replace the device. 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.

For example, if a hospital is replacing a single chamber pacemaker with a dual chamber device, and the hospital usually charges $8,000 for a single chamber pacemaker that costs $4,000 and charges $10,000 for a dual chamber device and gets a full credit of $4,000 for the single chamber device, they should charge $2,000 for the dual chamber device (the difference between $10,000 and $8,000).

Hospitals should not report modifier -FB when the hospital receives a credit for a failed device that appears on the table of devices subject to warranty or recall adjustment and the amount of the credit is less than the amount that the device would otherwise cost the hospital. For example, a device fails in the 6th month of a 1 year warranty and under the terms of the warranty, the hospital receives a credit of 50 percent of the cost of a replacement device. The hospital should not report modifier –FB on the procedure code

in which the device is implanted (see following question for guidance on partial credit scenarios).

Q. How should hospital outpatient departments bill when they receive partial credit for an implantable replacement device?

A. When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment found on the CMS website at http://www.cms.hhs.gov/HospitalOutpatientPPS/) and 2) receives a partial credit of 50 percent or more of the cost of the new replacement device, the hospital must append modifier –FC to the procedure code (not on the device code) that reports the service provided to replace the device.

For more information on billing for no cost/full credit or partial credit device replacements, see the Medicare Claims Processing Manual, Chapter 4, Section 61.3.

Q. How can a hospital outpatient department bill when they do not know at the time of the procedure whether they will receive a full or partial credit for an implantable device being removed?

A. When hospitals do not know at the time the device replacement procedure takes place whether or how much credit the manufacturer will provide for the device, hospitals have the option of either: (1) submitting the claim immediately without the – FB or -FC modifier and submitting a claim adjustment with the –FB or -FC modifier at a later date once the credit determination is made; or (2) holding the claim until a determination is made on the level of credit.