News Flash – Medicare Remit Easy Print (MREP) – Still using Standard Paper Remittance Advices (SPRs)? Did you know that with the new MREP software that is available to you (for free!), you can view and print as many or as few claims as needed? With the MREP software, you can navigate and view an Electronic Remittance Advice (ERA) using your personal computer. This is especially helpful when you need to print only one claim from the Remittance Advice (RA) when forwarding a claim to a secondary payer. CMS developed the MREP software to enable you to read and print the HIPAA-compliant ERA, also known as Transaction 835 or “the 835”. Contact your carrier, A/B MAC or DME MAC to find out more about MREP and/or for information on how to receive HIPAA compliant ERAs.

MLN Matters Number: SE0732 Related Change Request (CR) #: CR5668
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Note: This article was updated on August 28, 2012, to reflect current Web addresses. All other information is the same.

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

Provider Types Affected

Providers submitting claims to Medicare contractors (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.

Provider Action Needed

STOP – Impact to You
This article informs affected providers of how partial credits for medical devices are to be reported and paid under the OPPS and ASC payment systems.

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CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is implementing a partial device credit policy for hospitals paid under the OPPS and for ASCs paid under the revised ASC payment system (for services furnished on or after January 1, 2008). The partial credit policy applies to the same devices, Ambulatory Payment Classifications (APCs), and ASC procedures to which the no cost or full credit policy applies. Medicare payment will be reduced by 50 percent of the estimated cost of the device (i.e., the device offset percentage) in cases in which the hospital or ASC reports that it received a partial credit of 50 percent or more of the cost of the new device that is being implanted. See the table of applicable APCs at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html for the percentage reduction to the payment when the hospital reports a partial credit of 50 percent or more for a specified replacement device (also listed in those tables).

A table of covered ASC surgical procedures to which the partial device credit policy applies is available at http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html on the CMS website. Table 58 provides the device offset percentages for the selected OPPS APCs to which the partial device credit policy applies under the revised ASC payment system. ASCs will receive the same amount of payment reduction (in dollars) as a hospital when reporting a partial credit for a new replacement device.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding this change.

Background

In general, 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 APC payment for the procedure is based. Thus, when the provider receives partial credit for the device and therefore, 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.

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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.


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 lists of affected devices and APCs is located at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html) on the CMS website.


Effective January 1, 2008, CMS is also implementing a partial device credit policy under both the OPPS 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.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html) 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.

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: (1) 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 (2) 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.

Following are some hypothetical examples that illustrate the revised policy:

**OPPS Examples (all payment amounts are hypothetical):**

<table>
<thead>
<tr>
<th>Example</th>
<th>HCPCS</th>
<th>Description</th>
<th>SI</th>
<th>Units</th>
<th>APC</th>
<th>Unadjusted Payment</th>
<th>Offset Value</th>
<th>New Unadj. Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim 1:</td>
<td>33240 FB</td>
<td>Implant ICD</td>
<td>T</td>
<td>1</td>
<td>0107</td>
<td>$18,000</td>
<td>$17,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Full Credit or No Cost Replacement Device</td>
<td>C1721</td>
<td>ICD</td>
<td>N</td>
<td>1</td>
<td>==</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>93005</td>
<td>EKG</td>
<td>S</td>
<td>1</td>
<td>0099</td>
<td>$24</td>
<td>---</td>
<td>$24</td>
</tr>
</tbody>
</table>

Because Claim 1 is being billed as a full credit or no cost replacement device, it receives the full offset of $17,000.

| Claim 2: | 33240 FC | Implant ICD | T | 1 | 0107 | $18,000 | $8,500 ($17,000 x 0.5) | $9,500 ($8,500 + $1,000) |
| Partial Credit Replacement Device | C1721 | ICD | N | 1 | == | --- | --- | --- |
| | 93005 | EKG | S | 1 | 0099 | $24 | --- | $24 |

Because Claim 2 is being billed with a partial credit replacement device, the offset is half of the full offset value.

| Claim 3: | 33240 FC | Implant ICD | T | 1 | 0107 | $18,000 | $8,500 ($17,000 x 0.5) | $9,500 ($8,500 + $1,000) |
| Multiple Procedure Discount and Partial Credit Replacement Device | C1721 | ICD | N | 1 | == | --- | --- | --- |
| | 93005 | EKG | S | 1 | 0099 | $24 | --- | $24 |
| 35180 | Fistula Repair | T | 1 | 0093 | $1,500 | --- | $750 ($1,500 x 0.5) |

Because Claim 3 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0093 is discounted according to the multiple procedure discount rule. If the payment for APC 0093 were greater than the payment for APC 0107 after discount for the partial device credit, the multiple procedure discount would have been applied to further discount payment for APC 0107. The post-offset payment rate is used in discount determination, rather than the pre-offset payment rate.

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Example | HCPCS | Description | SI | Units | APC | Unadjusted Payment | Offset Value | New Unadj. Payment |
--- | --- | --- | --- | --- | --- | --- | --- | --- |
Claim 4: Terminated Procedure and Partial Credit Replacement Device | 33240 FC and 73 | Implant ICD | T | 1 | 0107 | $18,000 | $8,500 ($17,000 x 0.5) | $4,750 ($8,500 + $1,000 x 0.5) |
C1721 | ICD | N | 1 | == | --- | --- | --- |
93005 | EKG | S | 1 | 0099 | $24 | --- | $24 |

Because Claim 4 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0107 is discounted due to the presence of modifier 73, which identifies the service as being terminated prior to the administration of anesthesia or initiation of the procedure.

Claim 5: FC Modifier on Partial Credit Replacement Device Line

| HCPCS | Description | SI | Units | APC | Unadjusted Payment | I/OCE Edit #75: Incorrect billing of FB or FC modifier |
--- | --- | --- | --- | --- | --- | --- |
33240 | Implant ICD | T | 1 | 0107 | --- |
C1721 FC | ICD | N | 1 | == | --- |
93005 | EKG | S | 1 | 0099 | --- |

Because the FC modifier is located on the line for the device, instead of the procedure used to implant the device, the claim is returned to the provider due to I/OCE Edit #75.

ASC Examples (All payment amounts are hypothetical):

Note: Payment for devices, with the exception of pass through devices, are packaged into payment for the device implantation procedure. In the below examples, the device is not shown as a separate line item on the ASC claim because, in order to ensure appropriate payment, ASCs should not report packaged devices as separate line items on the claim.

Example | HCPCS | Description | PI | Units | Unadjusted ASC Payment | Offset Value | New Unadj. Payment |
--- | --- | --- | --- | --- | --- | --- | --- |
Claim 1: Full Credit or No Cost Replacement Device
ASC implants ICD replacement device (procedure 33240, device C1721) and receives full credit or incurs no cost for the replacement device. | 33240 FB | Implant ICD | J8 | 1 | $17,500 | $17,000 | $500 |
<table>
<thead>
<tr>
<th>Example</th>
<th>HCPCS</th>
<th>Description</th>
<th>PI</th>
<th>Units</th>
<th>Unadjusted ASC Payment</th>
<th>Offset Value</th>
<th>New Unadj. Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim 2:                  Partial Credit Replacement Device</td>
<td>33240</td>
<td>Implant ICD</td>
<td>J8</td>
<td>1</td>
<td>$17,500</td>
<td>$8,500 ($17,000 x 0.5)</td>
<td>$9,000</td>
</tr>
<tr>
<td>ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim 3:                  Multiple Procedure Discount and Partial Credit Replacement Device</td>
<td>33240</td>
<td>Implant ICD</td>
<td>J8</td>
<td>1</td>
<td>$17,500</td>
<td>$8,500 ($17,000 x 0.5)</td>
<td>$9,000</td>
</tr>
<tr>
<td>ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device. ASC also performs an additional procedure (33218), to which the multiple procedure discount applies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claim 4:                  Terminated Procedure and Partial Credit Replacement Device</td>
<td>33240</td>
<td>Implant ICD</td>
<td>J8</td>
<td>1</td>
<td>$17,500</td>
<td>$8,500 ($17,000 x 0.5)</td>
<td>$4,500</td>
</tr>
<tr>
<td>ASC brings patient into operating room to implant ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device. ASC terminates the procedure prior to the administration of</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Example

<table>
<thead>
<tr>
<th>HCP</th>
<th>Description</th>
<th>PI</th>
<th>Units</th>
<th>Unadjusted ASC Payment</th>
<th>Offset Value</th>
<th>New Unadj. Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**anesthesia or initiation of the procedure.**

### Claim 5:

**FC modifier on Partial Credit Replacement Device Line**

ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device.

<table>
<thead>
<tr>
<th>HCP</th>
<th>Description</th>
<th>PI</th>
<th>Units</th>
<th>Unadjusted ASC Payment</th>
<th>Offset Value</th>
<th>New Unadj. Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>33240</td>
<td>Implant ICD</td>
<td>J8</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Incorrect billing** because ASCs may not report device HCPCS codes or device charges on a separate line on the claim. Device payment is packaged into payment for the device implantation procedure, and charges for the device should be included in the line-item charge for the device implantation procedure. This bill will not result in accurate payment because there is no ASC payment rate for the device, and the payment for the implantation procedure will be made at the lesser of the ASC charges or the ASC rate.

### Claim 6:

**Partial Credit Replacement Device But FC Modifier Not Reported on Procedure Code**

ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device, but fails to append the FC modifier to the procedure code.

<table>
<thead>
<tr>
<th>HCP</th>
<th>Description</th>
<th>PI</th>
<th>Units</th>
<th>Unadjusted ASC Payment</th>
<th>Offset Value</th>
<th>New Unadj. Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>33240</td>
<td>Implant ICD</td>
<td>J8</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Incorrect billing** if partial credit is known at the time of billing. FC modifier should have been appended to the procedure code. If partial credit is unknown at the time of billing and the partial credit is received by the ASC at a later time, the ASC should contact the contractor to request an adjustment.

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Disclaimer: The above claim examples are hypothetical only and aim to reflect the pricing concepts, effective January 1, 2008. The rates above do not represent actual payment rates.

Additional Information

To view the official instruction (CR5668) on which this article is based, providers may visit http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1383CP.pdf on the CMS website.

If you have any questions, please contact your Medicare carrier, FI, or A/B MAC at their toll-free number, which may be found on the CMS website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

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