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

Note: This article was updated on February 14, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on information from Change Request (CR) 4017, which revises language found in the *Medicare Claims Processing Manual, Pub 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) web sites 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.

CAUTION – What You Need to Know

See the CMS web site at
http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html
to identify codes for devices that must be billed by hospitals for services paid under OPPS, and use the CMS website at
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html to identify the device codes that must be reported *with* specific procedure codes for a claim to be accepted by OCE. Once at that page, the file of edits is under "Downloads" at the bottom of that

page. Send questions about the device code requirements on the CMS website to *outpatientpps@CMS.hhs.gov*.

 GO – What You Need to Do

Please see the *Background* section of this article for further details.

Background

Medicare intermediaries and providers subject to the OPPS are advised by CR4017 to refer to CMS web sites that contain the correct tables of HCPCS device codes and OCE edits that apply when procedures that require devices are billed under the OPPS. Under the OPPS, CMS bundles payment for an implantable device into the Ambulatory Payment Classification (APC) Groups payment for the procedure performed to insert the device.

Because the pass-through status of many device categories expired at the end of CY 2002, CMS discontinued the HCPCS C-codes that had been established to report pass-through devices in CY 2003. However, CMS found that the claims used to set payment rates for APCs that require devices ("device-dependent" APCs) frequently have packaged costs that are much lower than the cost of the devices associated with the procedures. CMS attributes this anomalous cost data in part to variable hospital billing practices.

To improve the specificity of claims data, CMS reestablished device C-codes and encouraged hospitals (on a voluntary basis) to report device codes and charges on claims for services associated with devices in CY 2004.

For CY 2005, CMS required hospitals to report device C-codes for devices used in procedures on their claims if appropriate device codes exist. The goal is to capture the costs of all devices utilized in procedures in the hospital claims data used to develop APC payment rates. Specifically with respect to device-dependent APCs paid under the OPPS, the objective is to base payment on single-bill claims data, without adjustment for erratic data.

On December 17, 2004, CR3606 (Transmittal 403) was issued, which announced that, effective April 1, 2005, CMS would edit for the presence of specified device codes when hospitals billed certain procedure codes under the OPPS.

The following tables contained in CR3606 (Transmittal 403) are now incorrect and obsolete:

- HCPCS codes for devices; and

- Procedure code to device code edits.

CR4017 points out the CMS web site locations that contain the correct and timely information. The web site information will be updated as needed, and any changes will be effective on the calendar quarter.

Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures

Effective January 1, 2005, hospitals paid under the OPPS (bill types 12X and 13X) that report procedure codes that require the use of devices **must also report** the applicable HCPCS codes and charges for all devices that are used to perform the procedures where such codes exist (regardless of whether there is an edit). This is necessary so that the OPPS payment for these procedures will be correct in future years in which the claims are used to create the APC payment amounts.

Current HCPCS codes for devices can be found at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/index.html on the CMS website.

Edits for Claims on Which Specified Procedures Are to Be Reported With Device Codes

The OCE will return to the provider any claim that:

- Reports an HCPCS code for a procedure listed in the table of device edits; and

- Does not also report at least one device HCPCS code required for that procedure.

The HCPCS codes for procedures listed in the table of Device Code Edits can be found at *http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html* on the CMS website. The link to the file of edits is under the "Downloads" at the lower half of the page at that web address.

The table of Device Code Edits shows the effective date for each edit. If the claim is returned to the provider for failure to pass the edits, the hospital will need to modify the claim by either correcting the procedure code or ensuring that one of the required device codes is on the claim before resubmission.

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:

Modifier	Description
52	**Reduced Services** - Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier - 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
73	**Discontinued outpatient procedure prior to anesthesia administration** - Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation, including sedation when provided, and being taken to the room where the procedure is to be performed, but prior to the administration of anesthesia (local, regional block(s), or general).
74	**Discontinued outpatient procedure after anesthesia administration** - Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc).

- 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 OPPS (bill types 12X and 13X) must:

- Use the specific HCPCS codes for devices as shown on the CMS web site on claims for procedures that use the devices; and

- Look to the CMS web site for the procedure code to device code edits that apply.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R658CP.pdf on the CMS website

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