



News Flash - The Medicare Learning Network's (MLN) Learning Management System (LMS) that hosts our web-based training courses and product ordering page will be unavailable for a period of approximately 7 to 10 days starting the week of September 22, 2008 while we perform system maintenance and upgrades. If you need MLN products or need to complete a web-based training course, it is recommended that you do so before September 17, 2008. Thank you for your interest in the Medicare Learning Network. If you have any questions, please send them to MLN@cms.hhs.gov.

MLN Matters Number: MM6050 **Revised**

Related Change Request (CR) #: 6050

Related CR Release Date: November 3, 2008

Effective Date: January 1, 2009

Related CR Transmittal #: R1628CP

Implementation Date: January 5, 2009

Payment for Implanted Prosthetic Devices for Medicare Part B Inpatients

Note: This article was revised on November 4, 2008, to reflect revisions made to CR6050, which was revised to reflect that the new C-Code discussed in CR6050 is HCPCS code C9899. This article was revised accordingly. In addition, the CR release date, transmittal number, and Web address for accessing CR6050 were revised. All other information remains the same.

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for implanted prosthetic devices provided to Medicare beneficiaries under Part B.

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 6050 which clarifies payment for implanted prosthetic devices for Medicare Part B inpatients.

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**CAUTION – What You Need to Know**

Change Request (CR) 6050 revises the Medicare Claims Processing Manual (Chapter 4, Section 240) to provide 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, on the date that the device is implanted, are hospital inpatients without Part A coverage of services, but with Part B coverage,

**GO – What You Need to Do**

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

Background

The Centers for Medicare & Medicaid Services (CMS) can designate medical and other health services (that are payable under the Medicare Outpatient Prospective Payment System (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 who do 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). Under Medicare PPSes, payment for these items is packaged into payment for the procedure in which they are implanted.

Change Request (CR) 6050 revises the Medicare Claims Processing Manual, (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)), Section 240 (Inpatient Part B Hospital Services)) to provide instructions regarding how Medicare contractors are to establish payment for providers subject to the OPPS for implanted prosthetic devices that are furnished to Medicare beneficiaries who are hospital inpatients not having Part A coverage of services on the date that the device is implanted.

Specifically, the manual is revised to specify that **providers must submit these services on a 12X type of bill, reporting a new HCPCS code (C9899) that will**

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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
- Who does not have Part A coverage of inpatient services on the date that the implanted prosthetic device is furnished.

By reporting the new C-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 manual is also revised to specify 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.

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.

Once the Medicare contractor determines that the device is covered, it will then determine the appropriate payment amount for the device.

The contractor shall begin this process by determining if the device has pass through status under the OPSS. 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 OPSS, the contractor will set the payment amount for the device at the lesser of the amount for the device, in the 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 shall 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

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amount of device cost that would be removed from an applicable 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.

See <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> for the amount of reduction to the APC payment that would apply in these cases. From this OPSS webpage, select "Device, Radiopharmaceutical and Procedure Edits" from the list on the left side of the page. 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 OPSS 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 C 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 C-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 CY 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.

Note that Medicare contractors will deny payment for an item reported with the new C9899 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 or PR (Patient Responsibility) and a claim adjustment reason code of 96 (Non-covered charges).

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. Such denials will contain a remittance

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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).

Note: The revised Medicare Claims Processing Manual, (Chapter 4 Part B Hospital (Including Inpatient Hospital Part B and OPPTS), Section 240 (Inpatient Part B Hospital Services)) is included as an attachment to CR 6050.

Additional Information

The official instruction, CR 6050, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1628CP.pdf> on the CMS website.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

News Flash - Flu Shot Reminder - Flu Season Is Coming! It's not too early to start vaccinating as soon as you receive vaccine. Encourage your patients to get a flu shot as it is still their best defense against the influenza virus. *(Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.)* And don't forget, health care workers also need to protect themselves. **Get Your Flu Shot. – Not the Flu. Remember** - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professions and their staff, visit http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS website. To order, free of charge, a quick reference chart on Medicare Part B Immunization Billing, go to http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS website.

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