Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html / on the CMS website.

MLN Matters Number: MM 5263 | Related Change Request (CR) #: CR 5263
Related CR Release Date: November 3, 2006 | Effective Date: January 1, 2007
Related CR Transmittal #: R1103CP | Implementation Date: January 2, 2007

Note: This article was updated on November 6, 2012, to reflect current Web addresses. All other information remains unchanged.

Reporting and Payment of No-Cost and Reduced-Cost Devices Furnished by Outpatient Prospective Payment System (OPPS) Hospitals

Provider Types Affected

Providers and suppliers submitting claims to Medicare Fiscal Intermediaries (FIs) for devices used in the process of providing services to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5263 which expands the definition of modifier – '*FB*' and further specifies how no-cost devices and reduced cost devices are to be reported and paid for by hospitals paid under the Outpatient Prospective Payment System (OPPS).

Background

In general, Medicare packages payment for devices into the payment for the service in which the device is used. In some cases, the cost of the device is a very large proportion of the cost for the procedure on which the APC payment for the procedure is based. Section 1862(a)(2) of the Social Security Act excludes payment for items or services for which neither the beneficiary nor any party on the beneficiary's behalf are liable. Therefore is it necessary to adjust the payment

for the APC so that it no longer includes payment for a device that is being furnished without cost to the beneficiary

Medicare requires that hospitals paid under OPPS must report the Healthcare Common Procedure Coding System (HCPCS) code for devices they use in performing a service, including those implanted in a patient (temporarily or permanently), and the Outpatient Code Editor (OCE) returns claims to the provider for selected HCPCS procedures if an approved HCPCS code for the device is not included on the claim.

In addition, the Medicare claims processing system used by FIs requires that there be a charge for each HCPCS code reported on the claim, and an OPPS hospital may not refrain from billing for a device furnished under warranty, without cost to the provider or beneficiary. Therefore, CMS authorized hospitals (in CR 3915) to report a token charge of less than $1.01 for the device in these cases, so that the claim could be processed. See the MLN Matters article associated with CR 3915 (Transmittal 599, June 30, 2005) at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3915.pdf on the CMS website

CMS subsequently announced in CR 4250 the creation of modifier '*FB*', with the following definition:

- *Item Provided Without Cost to Provider, Supplier or Practitioner (Examples, but not Limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)*. See the MLN Matters article associated with CR 4250 (Transmittal 804, January 3, 2006) at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM4250.pdf on the CMS website

CR 5263 expands the definition of modifier '*FB*' to include credits received for a replacement device by a hospital from a manufacturer or other entity effective January 1, 2007.

CR 5263 further revises the *Medicare Claims Processing Manual* (Chapter 4) which instructs OPPS hospitals to:

- Report modifier – '*FB*' on the same line as the procedure code (not the device code) for a service that requires a device:
  - For which neither the hospital, nor the beneficiary, is liable to the manufacturer; or
  - When the manufacturer gives credit for a device being replaced with a more costly device.

- Append modifier – '*FB'* to the procedure code (not the device code) that reports the services provided to replace the device when the hospital:
  - Replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html; and
  - Receives the device without cost from a manufacturer. The hospital must report a token charge for the device (less than $1.01) in the covered charges field; or
  - Receives a credit in the amount that the device being replaced would otherwise cost. 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.

Payment for the replacement procedure is reduced by the offset amount applicable to the Ambulatory Payment Classification (APC) for which the service was furnished. These offset amounts are displayed on the OPPS CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html on the CMS website

The following table includes hypothetical claim examples and aim to reflect the pricing concepts, effective January 1, 2007. The rates in the following examples do not represent actual payment rates because they are rounded to simplify the example claims scenarios.

Example	HCPCS	Description	SI	Units	Charge	APC	Unadjusted Payment	Offset Amount	New Unadj. Payment
Claim 1: Free ICD Device	G0297 FB	Implant ICD	T	1	$6000	107	$16,000	$14,000	$2,000
	C1772	ICD	N	1	$1	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
Claim 2: Credit for Device Upgrade	G0297 FB	Implant ICD	T	1	$6000	107	$16,000	$14,000	$2,000
	C1772	ICD	N	1	$5000	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
Claim 3: Multiple Procedure Discount	G0297 FB	Implant ICD	T	1	$6000	107	$16,000	$14,000	$1,000 ($2,000 x .5)
	C1772	ICD	N	1	$1	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
	33241	Removal Puls	T	1	$5,000	105	$2,500	---	$2,500

Example	HCPCS	Description	SI	Units	Charge	APC	Unadjusted Payment	Offset Amount	New Unadj. Payment
		Generator							
Claim 4: Terminated Procedure along with free device	G0297 FB and 73	Implant ICD	T	1	$6000	107	$16,000	$14,000	$1,000 ($2,000 x .5)
	C1772	ICD	N	1	$1	---	---	---	---
	93005	EKG	S	2	$100	99	$44	---	$44
Claim 5: FB Modifier on Free Device Line	G0297	Implant ICD	T	1	$6000	107	OCE Edit #75: Incorrect billing of FB modifier		
	C1772 FB	ICD	N	1	$1	---			
	93005	EKG	S	2	$100	99			

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1103CP.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

Flu Shot Reminder

Flu season is here! Medicare patients give many reasons for not getting their flu shot, including—"It causes the flu; I don't need it; it has side effects; it's not effective; I didn't think about it; I don't like needles!" The fact is that out of the average 36,000 people in the U.S. who die each year from influenza and complications of the virus, greater than 90 percent of deaths occur in persons 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk to your Medicare patients about the importance of getting their annual flu shot--and don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends. Get Your Flu Shot.** Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website: http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf on the CMS website