CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1383	**Date: NOVEMBER 23, 2007**
	Change Request 5668

NOTE: Change Request 5668, transmittal 1297 dated July 20, 2007, is rescinded and replaced with this transmittal. The replacement CR was necessary to correct an erroneous provider device credit threshold in the instruction. The provider must receive a credit from the device manufacturer of 50 percent or more, for a replacement device, in order to bill the FC modifier on the claim. Transmittal 1297 had incorrectly identified the necessary device credit threshold as 20 percent. All other information remains the same.

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

I. SUMMARY OF CHANGES: For services furnished on or after January 1, 2008, hospitals are required to report HCPCS modifier FC on 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 on the list of creditable APCs, and the hospital receives a credit of 50 percent or more of the cost of the new replacement device. In these cases, Medicare payment will be reduced by 50 percent of the estimated cost of the device included in the APC payment. This policy applies to the same devices and APCs 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 only in cases in which hospitals report the FC modifier for procedures assigned to an APC on the specified list. In the case of ASCs, for services furnished on or after January 1, 2008, the partial credit policy applies to the same device and procedure pairs 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 included in the procedure payment in cases in which the ASC reports that it received a credit of 50 percent or more of the cost of the new replacement device by appending the FC modifier to the device implantation procedure HCPCS code.

NEW / REVISED MATERIAL
**EFFECTIVE DATE: ***January 1, 2008
IMPLEMENTATION DATE: January 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	4/Table of Contents
R	4/61.3/Billing for Devices Replaced Without Cost to an OPPS Hospital or Beneficiary

	or for Which the Hospital Receives a Full or Partial Credit and Payment for OPPS Services Required to Replace the Device
R	4/61.3.2/Reporting and Charging Requirements When the Hospital Receives Full Credit for the Replaced Device Against the Cost of a More Expensive Replacement Device
R	4/61.3.3/Reporting Requirements When the Hospital Receives Partial Credit Against the Cost of a Replacement Device
N	4/61.3.4/Medicare Payment Adjustment

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

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Pub. 100-04	Transmittal: 1383	Date: November 23, 2007	Change Request: 5668

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

EFFECTIVE DATE: January 1, 2008

IMPLEMENTATION DATE: January 7, 2008

I. GENERAL INFORMATION

A. Background: This instruction specifies how partial credits for medical device are to be reported and paid under the Outpatient Prospective Payment System (OPPS). In general, Medicare packages the full payment for devices into the payment for the service in which the device is used by using only 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 Ambulatory Payment Classification (APC) payment for the procedure is based. Therefore, when the provider receives partial credit and therefore does not incur the full cost of the procedure, it is necessary to adjust the payment for APC so that the payment reflects the reduced cost of the device. This is necessary to provide an appropriate payment for the service and to ensure that the Medicare beneficiary's copayment liability is reduced where appropriate, to reflect the reduced cost of the device.

Effective for services furnished on or after January 1, 2007, Medicare implemented an adjustment to the payment for selected APCs for which the device is inserted in the patient and remains in the patient at least temporarily, when the device is furnished either without cost or with full credit for the cost of the device being replaced (See, Transmittal 1103, Change Request (CR) 5263 issued November 3, 2006, and the Medicare Claims Processing Manual, Pub.100-4, Chapter 4, Section 61.3). Hospitals report the occurrence of a no cost or full credit device to CMS by reporting the FB modifier on the line with the specified procedure code in which the specified no cost or full credit device is used.
The list of affected APCs and affected devices is located under "downloads" on the OPPS webpage at www.cms.hhs.gov/HospitalOutpatientPPS/.

It has come to our attention that partial credits occur more commonly than no cost or full device credits occur. We have been told 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 fails before 3 years of use and to prorate the credit further over time between 3 and 5 years after the initial device implantation, as the useful life of the device declines. In these cases, the hospital is not incurring the full cost of the device, although the Medicare payment is calculated based on the full cost of the device.

As a result of these cases, CMS is implementing the partial device credit policy in the OPPS and ASC settings effective January 1, 2008. Section 626 of the Medicare Prescription Drug, Improvement, and

Modernization Act of 2003 (MMA) requires implementation of a new ASC payment system not later than January 1, 2008. Transmittal 1245, CR 5572, issued May 18, 2007, includes the design and analysis instructions to contractors of the new ASC payment system. Due to the publication schedule for this CR, inclusion of the ASC partial device credit policy and associated contractor instructions are being included in this CR rather than CR5572. The list of procedures for which the partial device credit policy applies (FC modifier) is the same as the procedures for which the full device credit policy applies (FB modifier). The ASCFS file (identified in CR5572) includes a column for the payment amount when a procedure is billed with the FB modifier and a column for the payment amount when a procedure is billed with the FC modifier. Contractors shall use the payment information included in the ASCFS field name "partial device reduced price" when applying the FC modifier.

B. Policy: For services furnished on or after January 1, 2008, hospitals are required to report HCPCS modifier FC [Partial credit received for replaced device] on 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 on the list of creditable APCs, and the hospital received a credit of 50 percent or more of the cost of the new replacement device. See www.cms.hhs.gov/HospitalOutpatientPPS/ for the lists of APCs and devices to which this policy applies, and also the payment offset amounts. The partial credit policy applies to the same devices and APCs 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 included in the procedure payment in cases in which hospitals report the FC modifier for procedures on the list of specified APCs.

In ASCs, for services furnished on or after January 1, 2008, the partial credit policy applies to the same device and procedure pairs 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 included in the procedure payment in cases in which the ASC reports that it received a credit of 50 percent or more of the cost of the new replacement device by appending the FC modifier to the device implantation procedure code.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5668.1	The Integrated Code Editor (I/OCE) shall assign a Payment Adjustment Flag [#8] (Item provided with partial credit to provider) to lines that meet the following: • Have a HCPCS code –FC modifier and • Are assigned to APCs to which the reduction applies.											I/OCE
5668.2	The I/OCE shall use the partial offset APC payment rate (APC payment amount minus 50 percent of the established offset) as the rate used in the I/OCE's determination of which multiple procedure line(s) will be discounted.											I/OCE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5668.3	The OPPS PRICER shall reduce the unadjusted (pre-wage adjusted) APC payment by the amount of reduction specified for the applicable APC when an OPPS line is processed with a Payment Adjustment Flag #8.											OPPS PRICER
5668.4	The OPPS PRICER shall calculate coinsurance based on the reduced payment amount.											OPPS PRICER
5668.5	The I/OCE shall revise line item edit #75 to return to the provider claims when either modifier –FB or –FC is appended to a code with the status indicator other than S, T, V or X.											I/OCE
5668.6	The FI or MAC shall return to provider claims when either modifier –FB or –FC is appended to a code with status indicator other than S, T, V, or X.	X		X								
5668.7	The I/OCE shall apply the 50 percent terminated procedure discount to the offset APC amount on OPPS lines that contain an –FC modifier along with a terminated procedure modifier -52 or -73.											I/OCE
5668.8	Contractors shall pay ASCs reduced amounts for HCPCS submitted with the FC modifier. The reduced rates will be included on the ASC files furnished by CMS. NOTE: refer to Transmittal 1245, CR5572 for further information.	X			X				X			
5668.9	Contractors shall perform the FC modifier pricing determination prior to the application of the multiple procedure pricing reductions. NOTE: refer to Transmittal 1245, CR5572 for further information.	X			X				X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A/	DM	FI	CA	DM	RH	Shared-System Maintainers	OTHER

								FISS	MCS	VMS	CWF	
5668.10	A **special edition** provider education article will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the **special edition** provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. A separate MLN Matters article will not be published for this CR.	X		X								

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

B. For all other recommendations and supporting information, use this space: Not applicable.

V. CONTACTS

Pre-Implementation Contact(s): Carrie Bullock at 410-786-1947 with respect to OPPS reporting and payment policy. Joseph Bryson at 410-786-2986 with regard to changes to the OPPS Pricer. Diana Motsiopoulos at 410-786-3379 with regard to changes to the OPPS I/OCE.
Chuck Braver at 410-786-6719 for ASC payment policy, William Stojak at 410-786-6984 or Yvette Cousar at 410-786-2160 for ASC claims processing questions

Post-Implementation Contact(s): CMS Regional Office staff.

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Attachment

Attachment

OPPS Examples (all payment amounts are hypothetical):

Example	HCPCS	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 1: Full Credit or No Cost Replacement Device	33240 FB	Implant ICD	T	1	0107	$18,000	$17,000	$1,000
	C1721	ICD	N	1	---	---	---	---
	93005	EKG	S	1	0099	$24	---	$24
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: Partial Credit Replacement Devic	33240 FC	Implant ICD	T	1	0107	$18,000	$8,500 ($17,000 x 0.5)	$9,500 ($8,500 + $1,000)
	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: Multiple Procedure Discount and Partial Credit Replacement Device	33240 FC	Implant ICD	T	1	0107	$18,000	$8,500 ($17,000 x 0.5)	$9,500 ($8,500 + $1,000)
	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.								
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	33240	Implant ICD	T	1	0107	I/OCE Edit #75: Incorrect billing of FB or FC modifier
	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.						

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev. 1383, 11-23-07)

61.3 - Billing for Devices Replaced Without Cost to an OPPS Hospital or Beneficiary or for Which the Hospital Receives a *Full or Partial* Credit and Payment for OPPS Services Required to Replace the Device

(Rev. 1383; Issued: 11-23-07; Effective: 01-01-08; Implementation: 01-07-08)

61.3.2 - Reporting and Charging Requirements When the Hospital Receives *Full* Credit for the Replaced Device Against the Cost of a More Expensive Replacement Device

(Rev. 1383; Issued: 11-23-07; Effective: 01-01-08; Implementation: 01-07-08)

When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS Web site at: www.cms.hhs.gov/HospitalOutpatientPPS); and 2) receives a credit in the amount that the device being replaced would otherwise cost, the hospital must append modifier -FB to the procedure code (not on the device code) that reports the services 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.

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.

61.3.3 - Reporting Requirements When the Hospital Receives Partial Credit Against the Cost of a Replacement Device

(Rev. 1383; Issued: 11-23-07; Effective: 01-01-08; Implementation: 01-07-08)

When a hospital: 1) replaces a device listed on the table of devices subject to warranty or recall adjustment (found on the CMS Web site 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 services provided to replace the device.

61.3.*4* - Medicare Payment Adjustment

(Rev. 1383; Issued: 11-23-07; Effective: 01-01-08; Implementation: 01-07-08)

Effective January 1, 2007, Medicare payment is reduced by *the full credit* offset amount for specified device procedure codes reported with an -FB modifier. *Effective January 1, 2008, Medicare payment is reduced by the partial credit offset amount for specified procedure codes reported with an –FC modifier.* Only procedure codes that map to the Ambulatory Payment Classification groups (APCs) on the list of APCs subject to the adjustment, and are reported with *the* –FB *or -FC* modifier, will be reduced.

The Integrated Code Editor (I/OCE) assigns a payment adjustment flag when a code in an APC subject to an offset adjustment is billed with modifier-FB *or -FC*. The payment adjustment flag communicates to the OPPS PRICER that the payment for the procedure code line is to be reduced by the established full or partial offset amount for the APC to which the procedure code is assigned. *The I/OCE uses the offset APC payment rate (APC payment amount minus the established offset amount) as the rate used in the I/OCE's determination of which multiple procedure line(s) will be discounted.*

The OPPS PRICER then applies the multiple procedure discounting and terminated procedure discounting factors after offsetting the unadjusted APC payment rate. The offset reduction also is made to the unadjusted payment rate before wage adjustment, which ensures that the beneficiary's coinsurance is based on the reduced amount.

NOTE: For procedure codes assigned to the device-adjusted APCs, and for the amount of the reduction *applicable to modifiers –FB and –FC*, see the table of APCs and devices to which the offset applies on the CMS Web site at: www.cms.hhs.gov/HospitalOutpatientPPS/.