



**TOPIC:**

Billing CMS for replacement of cardiac pacemakers and defibrillators that have been recalled by the manufacturer.

**TOPIC OVERVIEW**

In the past few months certain models of defibrillators and cardiac pacemakers have been recalled. Medtronic and Guidant are two manufacturers who have recently recalled devices. Since no cost is incurred by the facility for the replacement device itself facilities often do not include a line item on the UB92 to charge for the device when it is inserted. Historically this did not create a problem. Recently an Outpatient Code Editor (OCE) edit was implemented that requires the billing of a device in addition to certain procedures. Based on the OCE edit claims are being returned to the provider. It has been unclear how to bill CMS for the removal and replacement of these devices.

The Center of Medicare & Medicaid Services (CMS) issued a directive on June 17, 2005 that outlines the steps to be taken to bill for the replacement devices. Advice on this topic was included in Publication 100-04, Transmittal 585, Change Request (CR) 3915 on pages 7–8. To review these pages of CR 3915 see Addendum A (attached).

**HIGHLIGHTS**

- Outpatient Code Editor (OCE) edit #71 requires a cardiac replacement device be billed as a line item in addition to the procedure. C-codes that capture some of these devices are listed in the Table 1. Cardiac procedures that include insertion of devices are listed in Table 2.

**Table 1 C-codes for some cardiac devices**

<b>HCP Code</b>	<b>Description</b>
C1721	Cardioverter-defibrillator, dual chamber (implantable)
C1722	Cardioverter-defibrillator, single chamber (implantable)
C1785	Pacemaker, dual chamber, rate-responsive (implantable)
C1786	Pacemaker, single chamber, rate-responsive (implantable)
C1882	Cardioverter-defibrillator, other than single or dual chamber (implantable)

**Table 2 Cardiac procedures that include insertion of devices**

<b>HCPSC Code</b>	<b>Description</b>
33206	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial
33207	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular
33208	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular
33212	Insertion or replacement of pacemaker pulse generator only; single chamber
33213	Insertion or replacement of pacemaker pulse generator only; dual chamber
G0297	Insertion of single chamber pacing cardioverter defibrillator pulse generator
G0298	Insertion of dual chamber pacing cardioverter defibrillator pulse generator
G0299	Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator
G0300	Insertion or repositioning of electrode lead(s) for dual chamber pacing cardioverter defibrillator and insertion of pulse generator

- The line item for the device must include a charge of \$0.00 or \$1.00
- The bill type must be 13x
- This payment methodology is to be applied to services provided as of April 1, 2005.

For further details refer to the documents identified under “Resources” and Addendum A.



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### **ACTIONS TO BE TAKEN**

- Review all claims returned to provider since April 1, 2005 for lack of a required cardiac device. These claims may be identified via the designation of OCE edit #71 – Claim lacks a required device code, along with the HCPCS procedure code.
- Rebill accounts when appropriate.
- If necessary update mapping to reflect the relationship between certain cardiac procedures and their devices that need to be captured with corresponding C-codes.
- If necessary update the charge capture process to create the option of charging for a recalled cardiac devices with a specific CDM entry that reflects a \$0.00 or \$1.00 charge rather than the usual charge for the device.

### **RESOURCES:**

- *CMS Publication 100-04 Medicare Claims Processing Manual, Transmittal 403, Change Request 3606*  
[http://www.cms.hhs.gov/manuals/pm\\_trans/R403CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R403CP.pdf)
- *CMS Publication 100-04 Medicare Claims Processing Manual, Transmittal 585, Change Request 3915, pages 7-8*  
[http://www.cms.hhs.gov/manuals/pm\\_trans/R585CP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R585CP.pdf)



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**ADDENDUM A: No-Cost Device Coding per Change Request 3915**

**“5. No-Cost Device Coding** Effective for services furnished on or after April 1, 2005, all hospitals paid under the OPSS must report a code for a device when reporting the code for inserting the device. (See Transmittal 403, CR 3606, issued December 17, 2004.) If an OPSS hospital fails to report a device code, edits installed in the outpatient code editor (OCE) for services furnished on or after April 1, 2005 will not allow the claim to be processed to payment. For example, if a hospital doesn't report the code for a pacemaker with the CPT code for the procedure performed to insert the pacemaker, OCE edits will cause the claim to be returned to the provider.

However, there are occasions when a hospital may furnish a device for surgical insertion for which it incurs no cost. These cases include, but are not limited to, devices replaced under warranty, due to recall, or due to defect in a previous device; devices provided in a clinical trial; or devices provided as a sample. The hospital charge for a device furnished to the hospital at no cost should equal \$0.00. Some hospitals paid under the hospital outpatient prospective payment system (OPSS) might ordinarily report neither a code nor a charge for a device for which it incurred no cost, which would result in the claim failing the device edits installed in the OCE. Other hospitals have billing systems, which require that a charge be reported for separately payable codes in order for the claim to be submitted for payment, even items for which the hospital incurs no cost.

Hospitals paid under the OPSS have asked that CMS clarify how devices furnished to beneficiaries for whom the hospital incurs no cost should be reported. Therefore, take immediate action to broadcast and disseminate the following instructions to hospitals for services furnished on or after April 1, 2005:

- Hospitals paid under the OPSS that surgically implant a device furnished at no cost to the hospital shall report the appropriate HCPCS code for the device on type of bill 13x.
- Hospitals paid under the OPSS that surgically implant a device furnished at no cost to the hospital shall report a charge of zero for the device, or, if the hospital's billing system requires that a charge be entered, the hospital shall submit a token charge (e.g. \$1.00) on the line with the device code.

We recognize that showing a charge for a device that has been furnished without cost is not optimal, but showing a token charge in this circumstance will allow claims for reasonable and necessary services that might otherwise be denied due to OCE edits to be paid, and will ensure that beneficiaries receive the care they need.”